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ABSTRACT

To determine critical deficiencies in institutional reform related to accreditation, data from surveys conducted by the Accreditation Council for Facilities for the Mentally Retarded were analyzed. Identified were critical standards with which significant proportions of the facilities surveyed did not comply, formulated was an object-classification scheme describing residential services, and evaluated was the presence or absence of trends. Data indicated that over two-thirds of all critical standards identified were covered in the requirement for provision of active habilitation programming to each resident, and that evaluation and program planning, documentation, physical environment and integration of the multihandicapped were ranked as the most critical facility deficiencies. (Included in five appendixes are the classified critical standards for all facilities surveyed and the list of 651 standards classified according to topical requirements for residential facilities.) (CL)

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Analysis of Data Emmanating from Surveys of Residential Facilities Conducted by the Accreditation Council for Facilities for the Mentally Retarded

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A Report to the U. S. Department of Health, Education, and Welfare

* * * * * *

Program for the Analysis of Deinstitutionalization Resources
The Council for Exceptional Children

David L. Braddock, Ph.D., Director

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I. INTRODUCTION

The purpose of the Accreditation Standards Study was to analyze data emmanating from accreditation surveys of residential facilities for mentally retarded persons. Underlying the study was a notion, that by identifying accreditation standards with which a significant number of facilities surveyed did not comply and by grouping these "critical standards" into object-classifications descriptive of residential services in action, we would uncover critical deficiencies in institutional reform vis-a-vis accreditation. This information was expected to be useful to program planners within the U. S. Department of Health, Education, and Welfare (HEW), and others, for targeting the deployment of resources to facilitate compliance with accreditation standards.

The accreditation standards chosen to be studied as trend indicators were selected by a Project advisory committee representing the HEW Developmental Disabilities Office and Rehabilitation Services Administration, the President's Committee on Mental Retardation, and the University of Oregon's Rehabilitation Research and Training Center in Mental Retardation. Standards selected for study were those promulgated by the Accreditation Council for Facilities for the Mentally Retarded (ACFMR). These standards, periodically revised, are contained in the document Standards for Residential Facilities for the Mentally Retarded (JCAH, 1974).

To be accredited by the ACFMR a facility must be eligible for survey. It must comply with certain legal requirements, conduct a self-survey, be surveyed on-site by ACFMR surveyors, and develop plans to achieve compliance with pertinent standards after self-survey and also after on-site survey.

In defining substantial or "full compliance" the ACFMR has divided a universe of nearly 2,000 standards into three categories on the basis of presumed import to adequate program operation. These categories were designated Category A, B, and C, respectively; A Category containing the most important standards (JCAH, 1973). A facility seeking accreditation must not be found by the on-site surveyors to be in less than full compliance with more than 15% of the standards applicable to it in Category A.

The on-site survey itself is directed toward disconfirming the results of the facility self-survey, a null hypothesis approach. It can only be known with unchallengeable certainty that a facility is in full compliance with a standard if determining conformity with that standard is independent of possible sampling error. For example, a facility either has a specific document asserting the rights of residents or it does not. However, determining compliance with most standards at the on-site survey is dependent on resident sampling. Size and selection of this sample does not apparently allow estimation of the degree to which a facility is in less than full compliance. Therefore, for all but a few standards, the only accurate statement of survey findings that can really be made is if a facility is or is not found to be in less than full compliance with a given standard. For brevity, the term "noncompliance" is operationally synonomous hereafter with the phrase "less than full compliance."

Description of Data

Survey data was obtained from 48 on-site surveys obtained directly from the ACFMR. A sample of these data appear as Appendix 4. The ACFMR adheres to strict rules of confidentiality regarding the public disclosure of information about individual facilities surveyed and the data obtained

for analysis reflect this. Data obtained were in the form of a list of standards indicating only the number of non-accredited facilities and also the number of accredited facilities that were found to be in less than full compliance with the standards listed. This information was keypunched on computer cards for possible use in future trend analysis studies. The standards listed were 651 Category A standards used in 48 surveys of residential facilities conducted in 21 states between June 1973 and September 1974. Cases, however, in which a given standard was not applicable to a facility surveyed were not indicated.

Thirteen of the 48 facilities in the sample were accredited after the on-site survey. Median size was 92 residents; range: 15-796. Accredited facilities were located in eight states: Arizona, Arkansas, Illinois (6), Louisiana, Minnesota, Nebraska, Ohio, and South Carolina. Twelve of these facilities were public facilities, including six mental retardation units in public psychiatric facilities. Also, one privately-operated facility was known to be among the accredited group. Thirty-three of the 35 non-accredited facilities in the sample were public facilities and two were private. Median size was 638; range: 30-2,438. Non-accredited facilities were located in 16 states: Arizona, California, Florida, Georgia, Illinois, Indiana, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, Rhode Island, Tennessee, and Texas. Twelve non-accredited facilities had resident populations of 1,000 or more. Ten of the non-accredited facilities surveyed were mental retardation units in public psychiatric facilities. One mental retardation unit in a private psychiatric facility was also among the non-accredited group. Compliance, however, could not be identified specific to

these facility categories.[1] Table 1 shows selected characteristics of facilities surveyed.

Table 1

Characteristics of Facilities Surveyed by Facility Category

Facility Category	N Facilities Surveyed	%	Median Number of Residents
Non-Accredited Facilities	35	72	638
Public	33	94	
Private	2	6	
Accredited Facilities	13	28	92
Public	12	92	
Private	1	8	
All Facilities	48	100	396
Public	45	93	
Private	3	7	

Seventy-six accreditation decisions on residential facilities had been made by the ACFMR as of May 1975.[2] The sample of facilities from which data was extracted and studied here represents about two-thirds of the residential facilities surveyed and decisioned by ACFMR as of that date. Recent data indicate there are 1,236 residential facilities for mentally retarded persons in the United States (National Center for Health Statistics, 1974). The facility sample is small and, of course, nonrandomly selected since facilities sought accreditation. The number of states represented (21), however, and the

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1 Descriptive information about the sample was obtained through personal communications with ACFMR Program Director, Dr. Kenneth Crosby, in letters dated February 25, May 27, July 9, and August 15, 1975 (telephone conversation).

2 As reported in a "Special Course on Accreditation" held during the 99th Annual Convention of the American Association on Mental Deficiency, Portland, Oregon, May 18-19, 1975.

fact that they are uniformly spread throughout the regions of the country probably allows a cautious confidence in the generalizability of the study findings. On a scientific basis alone, the findings must be viewed specific only to the residential facilities surveyed by the ACFMR during one period in time under the conditions, some known and some unknown, which existed at that time.

Analysis of Data: Method

The analysis technique utilized was classification and comparison, i.e., a meaningful ordering of the survey data into a logical form designed to provide coherent and potentially useful program planning information to public policymakers. To this end, an outline was developed containing five analysis tasks (Selltiz, Jahoda, Deutsch, & Cook, 1959).

1. Identification by inspection of standards with which a significant proportion of the facilities surveyed did not comply;

2. Classification of the "critical standards" identified in the above task into facility categories;

3. Development or adoption of an object-classification scheme descriptive of residential services in action;

4. Classification of the standards into the object-classification scheme; and

5. Evaluation of these classified data for the presence or absence of trends.

As indicated above, the specific course of the analysis was first to identify, by inspection, those standards with which a significant proportion of facilities surveyed did not comply. These so-called "critical standards" were identified by assuming and applying to the data an arbitrarily derived

criterion of significance of 40%.[3] The data were inspected to determine (a) the standards with which 14 or more non-accredited facilities were in noncompliance and (b) the standards with which five or more accredited facilities were in noncompliance. Recall that 35 facilities in the sample were non-accredited; thirteen were accredited. Data were also examined to identify (c) the "critical standards' specific to all facilities surveyed. Hence, the second analytical task executed was to classify the data into these three facility categories: Non-Accredited Facilities, Accredited Facilities, and All Facilities surveyed. Cases of inapplicability of a given standard to a facility surveyedwere not known; thus, the last category consisted operationally of standards which fit into both the non-accredited facilities category and the accredited facilities category. An illustration follows:

> Standard number 2.7.3.9.1 requires that..."appropriate individual furniture be accessible to the residents." Twenty-nine non-accredited facilities did not comply with this item. For facilities in this category, the standard met criterion and was designated "critical." Eight accredited facilities did not comply with this item, so for the accredited facility category, the standard was designated "critical." Since 14 or more non-accredited facilities and also five or more accredited facilities were in noncompliance with Standard number 2.7.3.9.1, it was designated "critical" for all facilities surveyed.

The third analytical task was to devise an object-classification scheme which would go beyond the mere identification of "critical standards" by facility categories and order these standards to reflect trends in residential services in action. Object-classifications chosen were those presently in use by the ACFMR for reporting survey findings to facilities surveyed. The ACFMR has recently begun using these "topical requirements"[4] in the stated

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[3] An 80% criterion of significance (28 or more facilities), discussed later, was used specific only to the Non-Accredited Facility Category.

[4] Note: "object-classification" and "topical requirement," as used hereafter, are synonomous.

hope that "this method of organizing the standards will be helpful to facility staffs as they seek to fulfill the fundamental requirements of the standards. Survey results expressed in this format will provide a picture of the facility's strengths and weaknesses (ACFMR, topical requirements, 1975)." The object-classifications utilized include five major topical requirements and 24 minor topical requirements, as shown in Table 2.

Employment of the object-classification scheme, the fourth analytical task, involved classifying all "critical standards" into major and minor topical requirements (see Appendix 5). Previous work by ACFMR simplified this task in providing some guideposts for the classification of all 651 standards so that comparisons within and among object-classifications could be made (ACFMR, topical requirements, 1975).

To conclude the analysis, object-classifications were evaluated for the presence or absence of trends. The absolute and proportional numbers of critical standards for each major and minor topical requirement were determined specific to each facility category. Then, topical requirements were rank-ordered by percentage and also by the absolute number of critical standards contained therein. Both proportional and absolute indicators for rank ordering were used to enhance the authenticity of trends noted and to allow for the possibility that accreditation might, one day, be made contingent on a facility's being required to comply with a certain percentage of the standards within a topical requirement (ACFMR, Special Course, 1975).[5] Trends thus revealed were expected to show the presence or absence of

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[5] In certain instances, the topical requirement scheme is reportedly used now for making accreditation decisions. A few facilities have not been in less than full compliance with more than 15% of the applicable Category A standards but have not been accredited because of failure to meet the requirement that Active Habilitation Programming be provided to each resident. (Dr. Kenneth Crosby, personal communication, August 15, 1975.)

Table 2

Topical Requirements (Object-Classifications) Descriptive of Residential Services in Action

I. PROVISION OF ACTIVE HABILITATION PROGRAMMING TO EACH RESIDENT

- A. General Requirements
- B. Interdisciplinary Process Requirements
- C. Evaluation and Program Planning Requirements
- D. Management of Program Delivery Requirements
- E. Resident Training Requirements
- F. Behavior Management Requirements
- G. Attention to Resident Health Needs Requirements
- H. Habilitation Service Requirements
- I. Staff Training and Consultation Requirements
- J. Staffing Requirements
- K. Documentation Requirements
- L. Facilities and Equipment Requirements

II. PROVISION OF SERVICES WITHIN A NORMALIZED AND NORMALIZING ENVIRONMENT

- A. General Normalization Requirements
- B. Community Integration Requirements
- C. Integration of Multihandicapped Requirements
- D. Rhythm of Life Requirements
- E. Physical Environment Requirements

III. ASSURANCE OF THE RIGHTS OF RESIDENTS AND THEIR FAMILIES

- A. General Rights-Assurance Requirements
- B. Rights of Residents Requirements
- C. Rights of Families Requirements

IV. EFFECTIVE ADMINISTRATIVE PRACTICES

- A. General Administrative Requirements
- B. Communication Requirements
- C. Records Requirements
- D. Research Requirements

V. MAINTENANCE OF A SAFE AND SANITARY ENVIRONMENT

Source: (ACMR, 1975)

major deficiencies of program and be arranged in a priority. These disclosures could be particularly useful for targeting the deployment of resources to facilitate compliance with the ACFMR standards.

Foreview

Study results are presented in subsequent sections in the following structure:

- Trends Noted Specific to Non-Accredited Facilities Surveyed
- Trends Noted Specific to Accredited Facilities Surveyed
- Trends Noted Specific to All Facilities Surveyed
- Summary and Comment

Trends are illustrated and discussed in each of these sections. The content of the individual standards identified as critical for each facility category is classified according to the object-classification previously described. This information was too bulky to present in the text and has been included as Appendices 1, 2, and 3 for non-accredited, accredited, and all facilities surveyed, respectively. The reader is encouraged to refer to these appendices to gain a better understanding of the essence of the object-classification scheme and of the programmatic deficiencies revealed. The reader desiring a quick overview of the study--purpose, method, and trends--may refer to the concluding section of the report, "Summary and Comment."

II. TRENDS

Trends Noted Specific to Non-Accredited Facilities Surveyed

Inspection of the data revealed that 181 standards met the 40% criterion of significance.[6] That is, 14 or more non-accredited facilities surveyed were in noncompliance with each of 181 critical standards. At least 28 facilities (an 80% criterion) were in noncompliance with 34 of these standards. Substantial numbers of the non-accredited facilities did not comply with standards related to:

- The provision of habilitation or rehabilitation services based on individual needs;
- The use of interdisciplinary teams for initial and periodic evaluation, program planning, and review of resident's needs;
- The size of living unit components;
- The use of direct-care personnel in training residents in self-help skills such as bathing, menstrual care, grooming, and the use of money;
- The provision of comprehensive, interdisciplinary initial and periodic evaluation, program planning, and followup related to the individual resident's needs in education, rehabilitation, psychological services, and in speech pathology and audiology;
- The provision of educational programs to severely and profoundly retarded residents and to all other residents for whom educational provisions may not be required by state laws, irrespective of age or ability;
- The use of physical seclusion;[7]

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[6] Critical standards content classified according to the object-classifications previously outlined appear as Appendix 1.

[7] The use of a directly monitored time-out room for not more than 15 minutes as a part of a behavior modification program meeting APPLICABLE STANDARDS, SUCH AS PARENTAL CONSENT, IS NOT CONSIDERED TO BE SECLUSION.

- The excessive use of chemical restraint;[8]
- The employment of sufficient qualified personnel in direct care service, dentistry, education, nursing, physical and occupational therapy, psychology, recreation, social services, speech pathology and audiology, and vocational training;
- The use of a chronologically continuous program plan record for each resident, specifying goals and objectives in behavioral terms;
- The impersonal nature of the physical environment and respect for the privacy of residents in bathing and toileting, ownership of personal property, individual furniture, and the like;
- The practice of peonage; and
- The observance of due process and other legal rights of residents at the age of majority and of certain rights for families of residents regarding involvement in planning, evaluation, and decision making.

The proportions of critical standards specific to all standards within each topical requirement are presented in Figure 1. Among the five major topical requirements, the proportion of critical standards in a given category ranged from 45% to 5%. In absolute terms, more than two-thirds of all standards identified as "critical" were specific to Provision of Active Habilitation Programming to Each Resident. Thirty-three percent of all 381 standards in this object-classification were critical as compared with 45% of the total of 57 standards contained in the Provision of Services Within a Normalized and Normalizing Environment requirement.

The rank order of proportions of critical standards content among the five major topical requirements (highest to lowest) is presented in Table 3.

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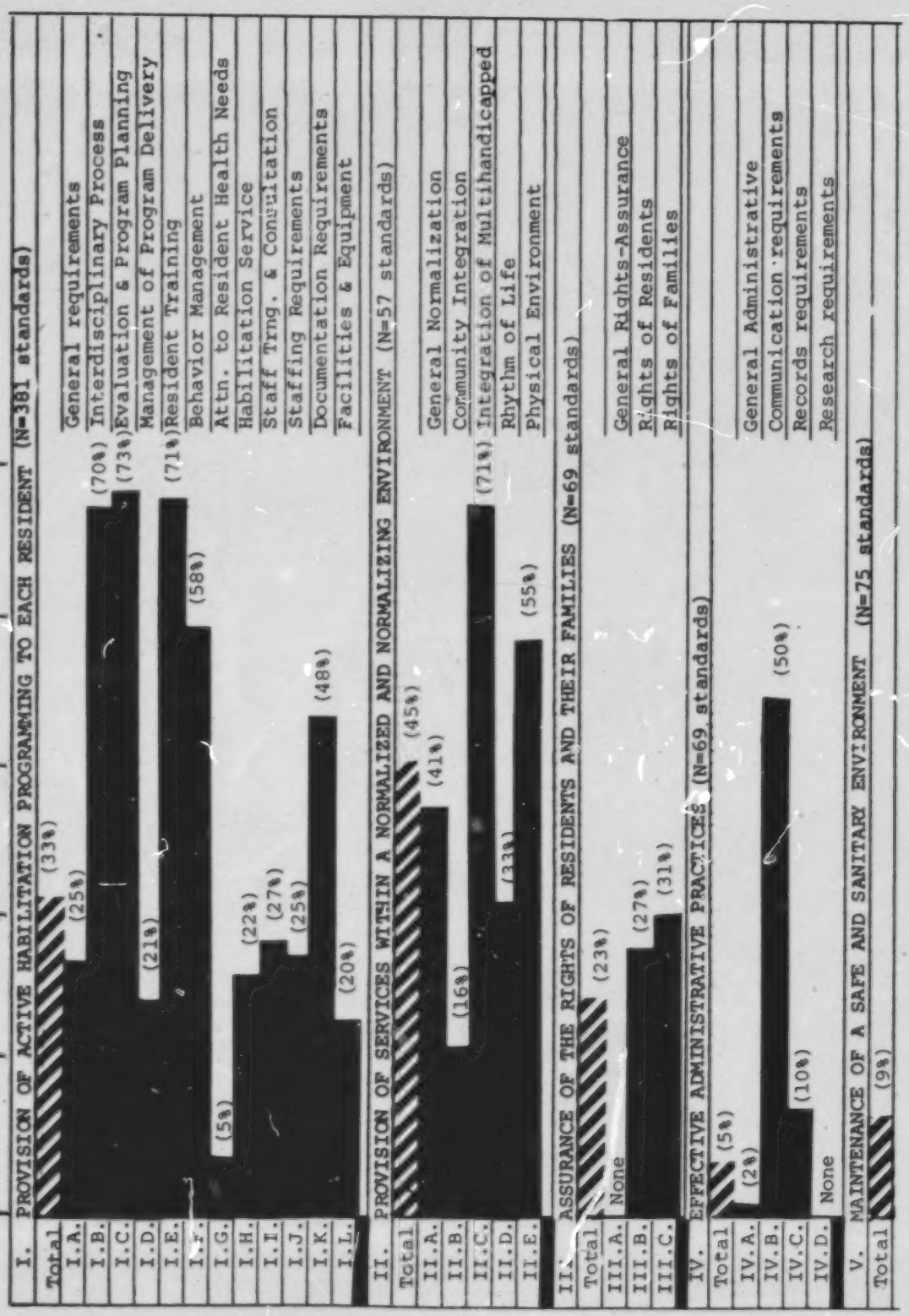
[8] The phrase "excessive use of chemical restraint" does not apply to the time-limited, physician prescribed use of drugs as part of an individual program plan designed by an interdisciplinary team to lead to a less restrictive way of managing and ultimately eliminating behaviors for which drugs were employed. The resident's record must show that less restrictive methods have been tried ineffectively. Excessive use implies substitution of chemicals for staff or program.

Figure 1

The Proportions of Critical Standards Among Non-accredited Facilities Surveyed Specific to Topical Requirements for Residential Facilities*


0
15
30
45
60
75
%
I. PROVISION OF ACTIVE HABILITATION PROGRAMMING TO EACH RESIDENT (N=381 standards)
Total (33%)
I.A. General requirements (25%)
I.B. Interdisciplinary Process (70%)
I.C. Evaluation & Program Planning (73%)
I.D. Management of Program Delivery (21%)
I.E. Resident Training (71%)
I.F. Behavior Management (58%)
I.G. Attn. to Resident Health Needs (5%)
I.H. Habilitation Service (22%)
I.I. Staff Trng. & Consultation (27%)
I.J. Staffing Requirements (25%)
I.K. Documentation Requirements (48%)
I.L. Facilities & Equipment (20%)
II. PROVISION OF SERVICES WITHIN A NORMALIZED AND NORMALIZING ENVIRONMENT (N=57 standards)
Total (45%)
II.A. General Normalization (41%)
II.B. Community Integration (16%)
II.C. Integration of Multihandicapped (71%)
II.D. Rhythm of Life (33%)
II.E. Physical Environment (55%)
III. ASSURANCE OF THE RIGHTS OF RESIDENTS AND THEIR FAMILIES (N=69 standards)
Total (23%)
III.A. General Rights-Assurance None
III.B. Rights of Residents (27%)
III.C. Rights of Families (31%)
IV. EFFECTIVE ADMINISTRATIVE PRACTICES (N=69 standards)
Total (5%)
IV.A. General Administrative (2%)
IV.B. Communication requirements (50%)
IV.C. Records requirements (10%)
IV.D. Research requirements None
V. MAINTENANCE OF A SAFE AND SANITARY ENVIRONMENT (N=75 standards)
Total (9%)

* 181 critical standards were identified, representing 27% of the universe of 651 standards inspected.

Table 3

Rank Order of Major Topical Requirements for Non-Accredited Facilities Surveyed by Highest to Lowest Proportion of Critical Standards Contained Therein

Rank	Major Topical Requirement	N Standards	N Critical Standards	Absolute Rank	% Critical Standards
1	Provision of Services Within a Normalized & Normalizing Environment	57	26	2	45
2	Provision of Active Habilitation Programming to Each Resident	381	128	1	33
3	Assurance of the Rights of Residents & their Families	69	16	3	23
4	Maintenance of a Safe and Sanitary Environment	75	7	4	9
5	Effective Administrative Practices	69	4	5	5
	TOTAL	651	181		27%

The particular array of critical standards within the major object-classifications, as displayed in Figure 1, warrants emphasis. Certain object-classifications, as depicted in Table 4, contained very high proportions of critical standards; others, very low proportions. Four requirements evidenced very high (70% or more) critical standards content. These rank ordered were: Evaluation and Program Planning, Resident Training, Integration of the Multihandicapped, and Interdisciplinary Process. Five other requirements showed between 58% and 41% critical standards content. Continuing the rank order, these respectively were: Behavior Management, Physical Environment, Communication, Documentation, and General Normalization requirements.

Nine requirements showed between 33% and 20% (moderate) critical standards content: Rhythm of Life, Rights of Families, Staff Training and Consultation, Rights of Residents, General Habilitation Programming, Staffing, Habilitation Service, Management of Program Delivery, and Facilities and Equipment requirements.

The six remaining object-classifications contained critical standards content between 16% and 0% (none). Completing the rank ordering, these were: Community Integration, Records, Attention to Resident Health Needs, General Administrative, Research, and General Rights Assurance requirements.

A second criterion of significance was utilized in the analysis of data emmanating from facilities in the non-accredited category. Data were inspected to identify standards with which 80% of the facilities (28 or more) were in noncompliance. As indicated previously, 34 standards met this criterion and were classified into the object-classifications previously employed. The rank order is similar to that apparent in data analyzed at

Table 4

Rank Order of Minor Topical Requirements for Non-Accredited Facilities Surveyed by Highest to Lowest Proportion of Critical Standards Contained Therein 40% Criterion of Significance

Rank	Minor Topical Requirement	N Standards	N Critical Standards	Absolute Rank	% Critical Standards
1	Evaluation and Program Plng.	53	39	1	73
2	Resident Training	14	10	4	71
3	Integration of the Multihandicapped	7	5	6	71
4	Interdisciplinary Process	10	7	5	70
5	Behavior Management	17	10	4	58
6	Physical Environment	18	10	4	55
7	Communication	2	1	10	50
8	Documentation	31	15	2	48
9	General Normalization	17	7	5	41
10	Rhythm of Life	9	3	8	33
11	Rights of Families	16	5	6	31
12	Staff Trng. & Consultation	18	5	6	27
13	Rights of Residents	40	11	3	27
14	General Habilitation Programming	28	7	5	25
15	Staffing	43	11	3	25
16	Habilitation Service	68	15	2	22
17	Management of Program Delivery	14	3	8	21
18	Facilities and Equipment	10	2	9	20
19	Community Integration	6	1	10	16
20	Records	20	2	9	10
*	Maintenance of a Safe & Sanitary Environment	75	7	5	9

continued---

*Major requirement. There are no subclassifications under this requirement.

Table 4 (Cont'd.)

21	Attention to Resident Health Needs	75	4	7	5
22	General Administrative	39	1	10	2
23	Research	8	0	--	0
24	General Rights Assurance	13	0	--	0
	TOTAL	651	181		27%

the 40% criterion of significance. As indicated in Table 5 and Figure 2, five of the same top six minor classifications are significant, in different order, however, at both 40% and 80% criterions. Note that the Resident Training requirement is top ranked at the 80% level. Also, 29 of the standards critical at the 80% level were specific to Provision of Active Habilitation Programming to Each Resident. This trend was also observed at the 40% criterion for non-accredited facilities. Table 5 presents the rank order for minor topical requirements at the 80% level.

Table 5

Rank Order of Minor Topical Requirements for Non-Accredited Facilities By Highest to Lowest Proportion of Critical Standards Contained Therein 80% Criterion of Significance

Rank	Minor Topical Requirement	N Standards	N Critical Standards	Absolute Rank	% Critical Standards
1	Resident Training	14	3	3	21
2	Interdisciplinary Process	10	2	4	20
3	Documentation	31	6	2	19
4	Evaluation & Program Plng.	53	8	1	15
5	Integration of the Multihandicapped	7	1	5	14
6	Physical Environment	18	2	4	11
7	General Habilitation Programming	28	3	3	10

Figure 2

The Proportions of Critical Standards Among Non-Accredited Facilities Surveyed Specific to Topical Requirements for Residential Facilities*

80% Criterion of Significance

0
15
30
45
60
75
I. PROVISION OF ACTIVE HABILITATION PROGRAMMING TO EACH RESIDENT (N=381 standards)
Total (7%)
I.A. General requirements (10%)
I.B. Interdisciplinary Process (20%)
I.C. Evaluation & Program Planning (15%)
I.D. Management of Program Delivery (7%)
I.E. Resident Training (21%)
I.F. Behavior Management None
I.G. Attn. to Resident Health Needs None
I.H. Habilitation Service (5%)
I.I. Staff Trng. & Consultation (5%)
I.J. Staffing Requirements (2%)
I.K. Documentation Requirements (19%)
I.L. Facilities & Equipment None
II. PROVISION OF SERVICES WITHIN A NORMALIZED AND NORMALIZING ENVIRONMENT (N=57 standards)
Total (7%)
II.A. General Normalization None
II.B. Community Integration (5%)
II.C. Integration of Multihandicapped (14%)
II.D. Rhythm of Life None
II.E. Physical Environment (11%)
III. ASSURANCE OF THE RIGHTS OF RESIDENTS AND THEIR FAMILIES (N=69 standards)
Total (1%)
III.A. General Rights-Assurance None
III.B. Rights of Residents None
III.C. Rights of Families (6%)
IV. EFFECTIVE ADMINISTRATIVE PRACTICES (N=69 standards)
Total (0%)
IV.A. General Administrative None
IV.B. Communication requirements None
IV.C. Records requirements None
IV.D. Research requirements None
V. MAINTENANCE OF A SAFE AND SANITARY ENVIRONMENT (N=75 standards)
Total (0%)

* 34 standards were identified, representing 5% of the universe of 651 standards inspected.

As illustrated in Figure 2, twelve object-classifications evidenced no critical standards content at the 80% criterion: Behavior Management, Health Needs, Facilities and Equipment, Community Integration, Rhythm of Life, General Rights Assurance, Rights of Residents, Administration, Communication, Records, Research, and Maintenance of a Safe and Sanitary Environment.

Trends Noted Specific to Accredited Facilities Surveyed

Inspection of all 651 standards revealed that 39 standards met the 40% criterion of significance.[9] That is, five or more accredited facilities surveyed were in noncompliance with each of the 39 critical standards. No accredited facilities surveyed met the 80% criterion of significance.

Substantial numbers of accredited facilities surveyed did not comply with standards relating to:

- The size of living unit components;
- The use of appropriately constituted interdisciplinary teams for evaluating resident's needs and planning an individualized program;
- The admittance of residents who have had a comprehensive evaluation;
- The requirements that there be individualized evaluation and program plans for each resident;
- The qualifications and number of direct-care staff;
- The use of chronologically continuous records for monitoring residents' evaluations, prognosis, program plans, and progress;
- The existence of architectural barriers for multihandicapped residents;
- The impersonal nature of the physical environment, lack of privacy in bathing and toileting; and
- The observance of due process rights at the time the resident attains the age of majority.

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[9]Critical standards classified according to the object-classifications outlined previously appear as Appendix 2.

The proportions of critical standards content among all standards within each major and minor topical requirement are presented in Figure 3. Among the five major topical requirements, the proportion of critical standards within a given category ranged from 15% to 0%. As with non-accredited facilities surveyed, two-thirds of all critical standards for accredited facilities surveyed were specific to Provision of Active Habilitation Programming to Each Resident. Six percent of the 381 standards in this object-classification were critical; and, as with non-accredited facilities surveyed, the highest percentage of the critical standards content was found specific to Provision of Services Within a Normalized and Normalizing Environment.

As shown in Table 6, for accredited facilities surveyed, the rank order among the top three ranked major topical requirements, proportionately and absolutely, is identical to the order discerned for non-accredited facilities surveyed. Topical requirements titled Maintenance of a Safe and Sanitary Environment, and Effective Administrative Practices, however, evidenced no critical standards for accredited facilities.

Table 6

Rank Order of Major Topical Requirements for Accredited Facilities Surveyed by Highest to Lowest Proportion of Critical Standards Contained Therein

Rank	Major Topical Requirement	N Standards	N Critical Standards	Absolute Rank	% Critical Standards
1	Provision of Services Within A Normalized & Normalizing Environ.	57	10	2	15
2	Provision of Active Habilitation Programming	381	26	1	6
3	Assurance of the Rights of Residents	69	3	3	4
4	Effective Administrative Practice	69	0	0	0
5	Maintenance of a Safe & Sanitary Environment	75	0	0	0
	TOTAL	651	39		5%

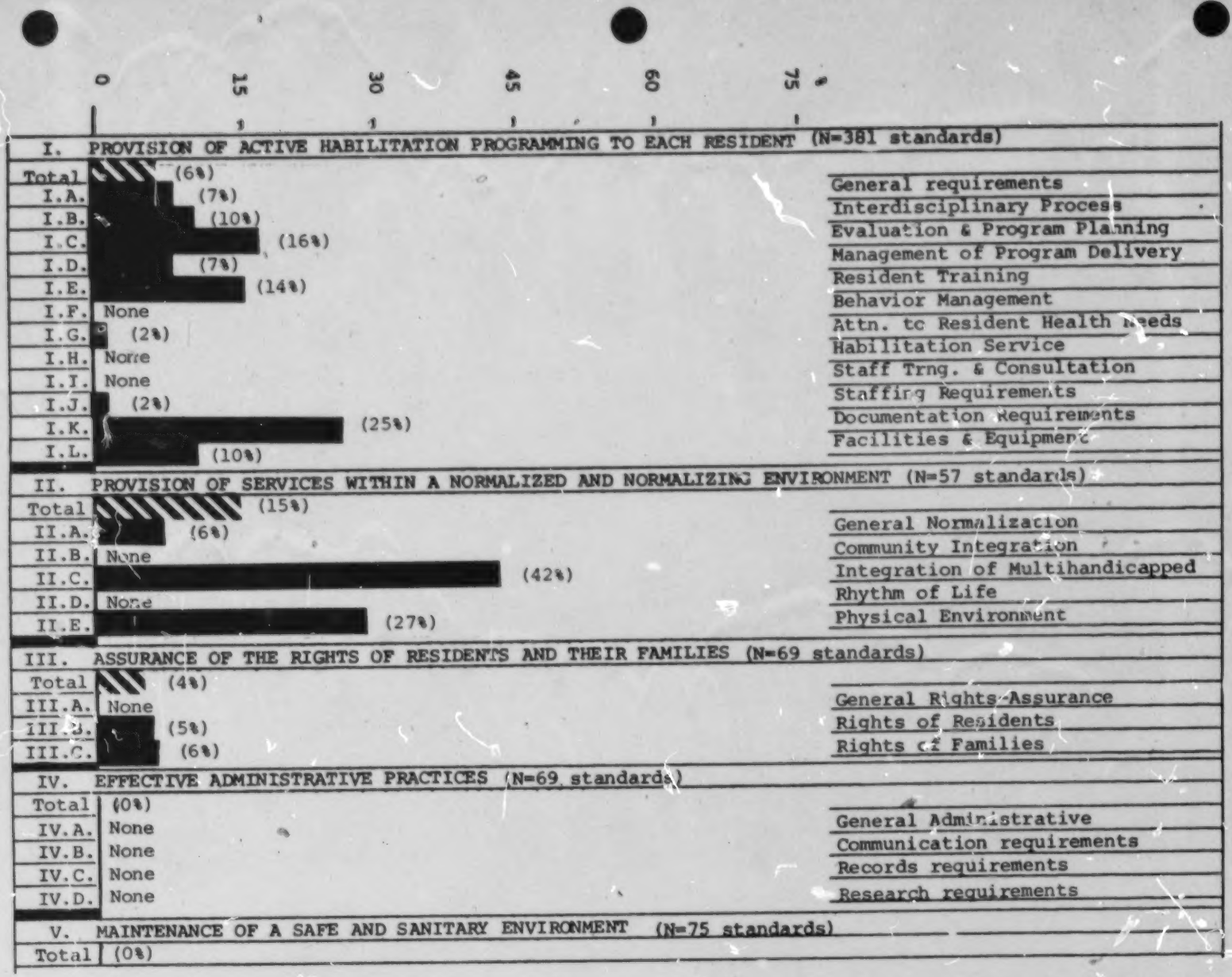
0
15
30
45
60
75
I. PROVISION OF ACTIVE HABILITATION PROGRAMMING TO EACH RESIDENT (N=381 standards)
Total (6%)
I.A. (7%) General requirements
I.B. (10%) Interdisciplinary Process
I.C. (16%) Evaluation & Program Planning
I.D. (7%) Management of Program Delivery
I.E. (14%) Resident Training
I.F. None Behavior Management
I.G. (2%) Attn. to Resident Health Needs
I.H. None Habilitation Service
I.I. None Staff Trng. & Consultation
I.J. (2%) Staffing Requirements
I.K. (25%) Documentation Requirements
I.L. (10%) Facilities & Equipment
II. PROVISION OF SERVICES WITHIN A NORMALIZED AND NORMALIZING ENVIRONMENT (N=57 standards)
Total (15%)
II.A. (6%) General Normalization
II.B. None Community Integration
II.C. (42%) Integration of Multihandicapped
II.D. None Rhythm of Life
II.E. (27%) Physical Environment
III. ASSURANCE OF THE RIGHTS OF RESIDENTS AND THEIR FAMILIES (N=69 standards)
Total (4%)
III.A. None General Rights Assurance
III.B. (5%) Rights of Residents
III.C. (6%) Rights of Families
IV. EFFECTIVE ADMINISTRATIVE PRACTICES (N=69 standards)
Total (0%)
IV.A. None General Administrative
IV.B. None Communication requirements
IV.C. None Records requirements
IV.D. None Research requirements
V. MAINTENANCE OF A SAFE AND SANITARY ENVIRONMENT (N=75 standards)
Total (0%)

Figure 3

The Proportions of Critical Standards Among Accredited Facilities Surveyed Specific to Topical Requirements for Residential Facilities

25

Within minor object-classifications, the proportions of critical standards content varied from 42% to 0%. The top four proportionately ranked classifications, as shown in Table 7, were: Integration of the Multihandicapped, Physical Environment, Documentation, and Evaluation and Program Planning. The same requirements were significant in absolute terms, however, in inverse order. These four classifications contained over two-thirds of all critical standards for accredited facilities surveyed.

Table 7

Rank Order of Minor Topical Requirements for Accredited Facilities Surveyed by Highest to Lowest Proportion of Critical Standards Contained Therein

Rank	Minor Topical Requirement	N Standards	N Critical Standards	Absolute Rank	% Critical Standards
1	Integration of Multihandicapped	7	3	4	42
2	Physical Environment	18	5	3	27
3	Documentation	31	8	2	25
4	Evaluation & Program Plng.	53	9	1	16
5	Resident Training	14	2	5	14
6	Interdisciplinary Process	10	1	6	10
6	Facilities & Equipment	10	1	6	10
7	Management of Program Delivery	14	1	6	7
7	General Habilitation	28	2	5	7
8	General Normalization	17	1	6	6
8	Rights of Families	16	1	6	6
9	Rights of Residents	40	2	5	5
10	Attention to Resident Health Needs	75	2	5	2
11	Staffing	43	1	6	2
12	All other requirements	376	0	0	0
	TOTAL	651	39	-	5%

Trends Noted Specific to All Facilities Surveyed

Inspection of all 651 standards revealed that 37 standards met the 40% criterion of significance.[10] That is, 14 or more non-accredited facilities surveyed and also five or more accredited facilities surveyed were in non-compliance with each of 37 critical standards. Recall, that as discussed in the methodology section, the All Facilities Surveyed facility category was operationally defined in this manner. Hence, precisely as with facilities in the accredited category, substantial numbers of facilities in the all facilities surveyed category did not comply with standards relating to:

- The size of living unit components;
- The use of appropriately constituted interdisciplinary teams for evaluating resident's needs and planning an individualized program;
- The admittance of residents who have had a comprehensive evaluation;
- The requirements that there be individualized evaluation and program plans for each resident;
- The qualifications and number of direct-care staff;
- The use of chronologically continuous records for monitoring residents' evaluations, prognosis, program plans, and progress;
- The existence of architectural barriers for multihandicapped residents;
- The impersonal nature of the physical environment, lack of privacy in bathing and toileting; and,
- The observance of due process rights at the time the resident attains the age of majority.

The proportions of critical standards among all standards within each major and minor object-classification are presented in Figure 4. Graphical configurations are nearly identical with those discovered in the classification and analysis of data in the accredited facilities surveyed category.

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[10] Critical standards for all facilities surveyed classified according to object-classifications appear as Appendix 3.

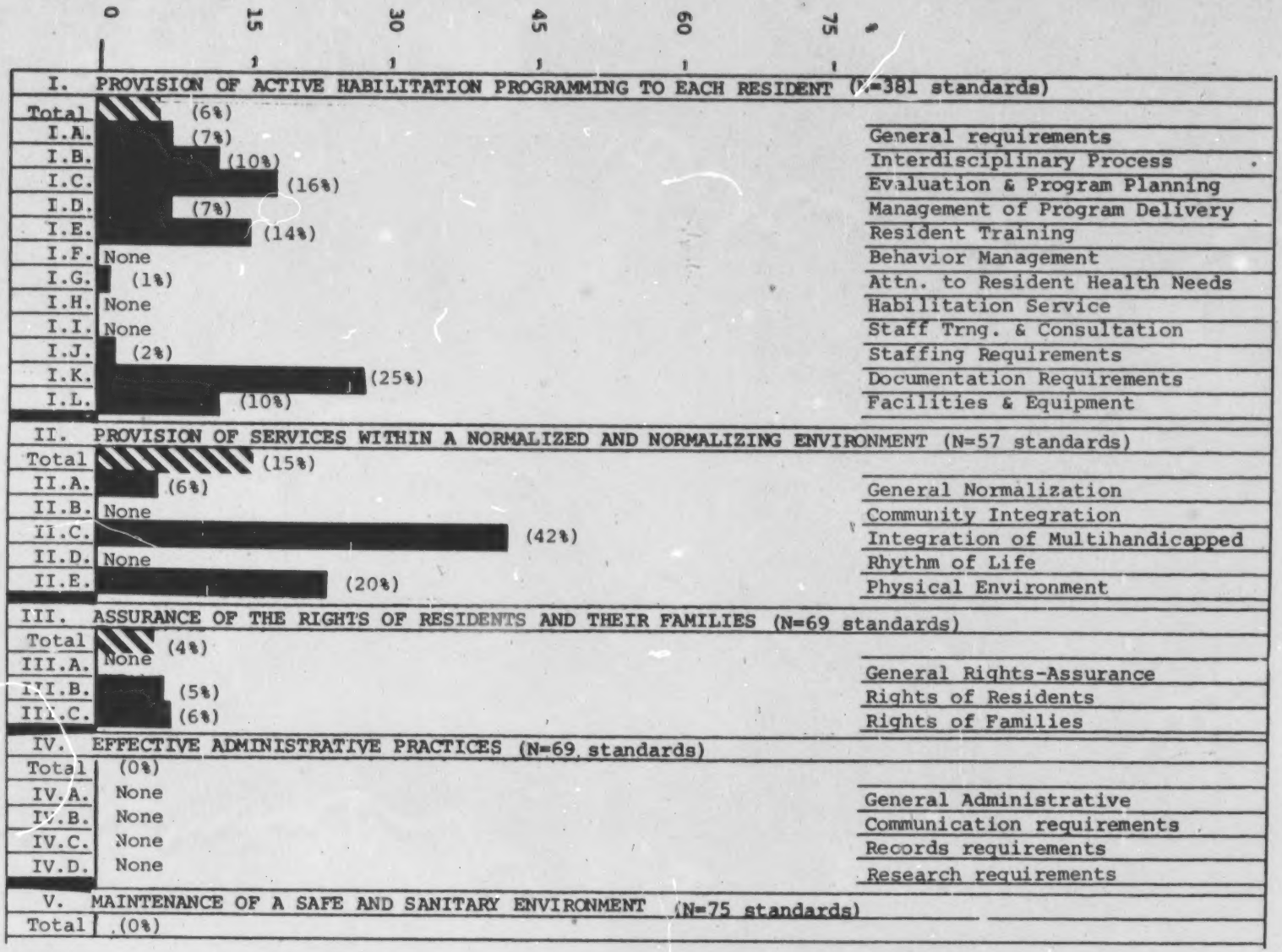
0
15
30
45
60
75
%
I. PROVISION OF ACTIVE HABILITATION PROGRAMMING TO EACH RESIDENT (N=381 standards)
Total (6%)
I.A. (7%) General requirements
I.B. (10%) Interdisciplinary Process
I.C. (16%) Evaluation & Program Planning
I.D. (7%) Management of Program Delivery
I.E. (14%) Resident Training
I.F. None Behavior Management
I.G. (1%) Attn. to Resident Health Needs
I.H. None Habilitation Service
I.I. None Staff Trng. & Consultation
I.J. (2%) Staffing Requirements
I.K. (25%) Documentation Requirements
I.L. (10%) Facilities & Equipment
II. PROVISION OF SERVICES WITHIN A NORMALIZED AND NORMALIZING ENVIRONMENT (N=57 standards)
Total (15%)
II.A. (6%) General Normalization
II.B. None Community Integration
II.C. (42%) Integration of Multihandicapped
II.D. None Rhythm of Life
II.E. (20%) Physical Environment
III. ASSURANCE OF THE RIGHTS OF RESIDENTS AND THEIR FAMILIES (N=69 standards)
Total (4%)
III.A. None General Rights-Assurance
III.B. (5%) Rights of Residents
III.C. (6%) Rights of Families
IV. EFFECTIVE ADMINISTRATIVE PRACTICES (N=69 standards)
Total (0%)
IV.A. None General Administrative
IV.B. None Communication requirements
IV.C. None Records requirements
IV.D. None Research requirements
V. MAINTENANCE OF A SAFE AND SANITARY ENVIRONMENT (N=75 standards)
Total (0%)

Figure 4

The Proportions of Critical Standards Among All Facilities Surveyed Specific to Topical Requirements for Residential Facilities

28

In fact, only two standards were judged critical for facilities in the accredited facilities surveyed category, but were not judged critical for non-accredited facilities surveyed. These standards state that:

> "Each living unit shall have a properly adapted drinking unit" (Standard number 2.4.3); and
>
> "No medication shall be administered to a resident without a written order by a physician" (Standard number 3.8.6.3.4).

Non-accredited facilities not complying with the first standard numbered 13; the latter, 6. If a standard was judged critical for accredited facilities surveyed, the probability was over 90% that it was also judged critical for non-accredited facilities and therefore, for all facilities surveyed.

The rank order for all facilities surveyed of proportions of critical standards among major and minor topical requirements appears as Table 8. Among major requirements, the rank order for facilities in the all facilities surveyed category is identical proportionately and absolutely to the rank order for accredited facilities surveyed. And, in absolute terms, Provision of Active Habilitation Programming to Each Resident also contains most (two-thirds) of the critical standards in this facility category.

Within the minor object-classifications, the proportions of critical standards content varied from 42% to 0%. This rank order, with two exceptions, is also identical to the rank order for facilities in the accredited facility category. Physical Environment changes ranks with Documentation proportionately, but not absolutely, and Resident Health Needs drops a notch proportionately and absolutely.

Table 8

Rank Order of Major Topical Requirements for All Facilities Surveyed By Highest to Lowest Proportion of Critical Standards Contained Therein

Rank	Major Topical Requirement	N Standards	N Critical Standards	Absolute Rank	% Critical Standards
1	Provision of Services Within A Normalized & Normalizing Environment	57	8	2	14
2	Provision of Active Habilitation Programming to Each Resident	381	26	1	6
3	Assurance of the Rights of Residents and their Families	69	3	3	4
4	Maintenance of a Safe and Sanitary Environment	75	0	0	0
4	Effective Admin. Practice	69	0	0	0
	TOTAL	651	37		5%

In absolute terms, over two-thirds of the standards judged critical for facilities in the all facilities surveyed category fell into four object-classifications: Evaluation and Program Planning, Documentation, Physical Environment, and Integration of the Multihandicapped. Table 9 shows the rank order of minor topical requirements for all facilities surveyed.

Table 9

Rank Order of Minor Topical Requirements for All Facilities Surveyed by Highest to Lowest Proportions of Critical Standards Contained Therein

Rank	Minor Topical Requirement	N Standards	N Critical Standards	Absolute Rank	% Critical Standards
1	Integration of the Multi-handicapped	7	3	4	42
2	Documentation	31	8	2	25
3	Physical Environment	18	4	3	22
4	Evaluation & Prog. Planning	53	9	1	16
5	Resident Training	14	2	5	14
6	Interdisciplinary Process	10	1	6	10
6	Facilities & Equipment	10	1	6	10
7	Management of Program Delivery	14	1	6	7
7	General Habilitation	28	2	5	7
8	Rights of Families	16	1	6	6
8	General Normalization	17	1	6	6
9	Rights of Residents	40	2	5	5
10	Staffing	43	1	6	2
11	Attention to Resident Health Needs	75	1	6	1
12	All other requirements	376	0	0	0
	TOTAL	651	37	-	5%

III. SUMMARY AND COMMENT

Purpose

The purpose of the Accreditation Standards Study was to analyze data emmanating from surveys conducted by the Accreditation Council for Facilities for the Mentally Retarded. Underlying the study was a notion that, by identifying specific standards with which a significant number of facilities surveyed did not comply and by grouping these "critical standards" into object-classifications descriptive of residential services in action, we would uncover critical deficiencies in institutional reform vis-a-vis accreditation. This information was expected to be useful to program planners in the Department of HEW, and others, for targeting the deployment of resources to facilitate compliance with ACFMR standards.

The Data

The survey data analyzed was obtained from the ACFMR in keeping with that organization's obligations regarding confidentiality of survey data. Data obtained consisted only of a list indicating the number of non-accredited facilities and the number of accredited facilities found to be in less than full compliance (hereafter, noncompliance) with the standards listed. This information was keypunched for possible use in future trend analysis studies. Inapplicability of a standard to a given facility surveyed was not indicated. Standards listed were the 651 Category A standards used in 48 on-site residential facility surveys conducted in 21 states between June 1973 and September 1974. Thirteen of these facilities were accredited after the survey; 35 were not. The median facility size (number of residents) was 396. A limitation of the study was that the sample was small and, although national representation was uniform regionally, it was nonrandomly selected--facilities sought accreditation.

It was known that seventy-two percent (35) of the 48 facilities in the sample were not accredited after survey. Twenty-eight percent (13) were accredited. Ninety-three percent (45) of the facilities in the sample were public facilities; seven percent (3) were private. One-third of all facilities, including 10 of the non-accredited facilities, were mental retardation units in psychiatric facilities. The median number of residents for non-accredited facilities surveyed was 638; for accredited facilities, 92; for all facilities surveyed, 396. The range was 15-2,438. Twelve facilities (all non-accredited) had 1,000 or more residents.

The number of states represented and the fact that they are uniformly spread throughout the regions of the country probably allows a cautious confidence in the generalizibility of the study findings. However, on a scientific basis alone, the findings must be viewed specific only to the residential facilities surveyed by the ACFMR during one period in time under the conditions, some known and some unknown, which existed at that time.

Method

A five-task analysis outline was developed to guide the research (Selltiz, Jahoda, Deutsch, & Cook, 1959).

Tasks executed were:

- Identification by inspection of standards with which significant proportions (40% and 80%) of the facilities surveyed did not comply;

- Classification of these "critical standards" into three facility categories: Non-Accredited Facilities Surveyed, Accredited Facilities Surveyed, and All Facilities Surveyed;

- Adoption of detailed object-classification scheme (5 major categories, 24 minor) descriptive of residential services in action;

- Classification of the standards into the various categories (topical requirements) contained in the object-classification scheme; and

- Evaluation of critical standards content in the object-classification scheme for the presence or absence of trends.

The constituent elements of the object-classification scheme (ACFMR, topical requirements, 1975) are presented as follows:

I. Provision of Active Habilitation Programming to Each Resident

- A. General requirements
- B. Interdisciplinary process requirements
- C. Evaluation and program planning requirementsx
- D. Management of program delivery requirements
- E. Resident training requirements
- F. Behavior management requirements
- G. Attention to resident health needs requirements
- H. Habilitation service requirements
- I. Staff training and consultation requirements
- J. Staffing requirements
- K. Documentation requirements
- L. Facilities and equipment requirements

II. Provision of Services Within a Normalized and Normalizing Environment

- A. General normalization requirements
- B. Community integration requirements
- C. Integration of multihandicapped requirements
- D. Rhythm of life requirements
- E. Physical environment requirements

III. Assurance of the Rights of Residents and Their Families

- A. General rights-assurance requirements
- B. Rights of residents requirements
- C. Rights of families requirements

IV. Effective Administrative Practices

- A. General administrative requirements
- B. Communication requirements
- C. Records requirements
- D. Research requirements

V. Maintenance of a Safe and Sanitary Environment

Trends Noted

Results were generated specific to each facility category. For Non-Accredited Facilities Surveyed, 14 or more facilities did not comply with each of 181 standards. The median number of persons in residence was 638--nearly seven times the number in residence in accredited facilities. Among the five major object-classifications (i.e., topical requirements) employed, the proportion of critical standards content ranged from a high of 45% in Provision of Services Within a Normalized and Normalizing Environment, to a low of 5% in Effective Administrative Practices. In absolute terms, however, the requirement Provision of Active Habilitation Programming to Each Resident contained over two-thirds of all critical standards identified.

Further, the molecular array of critical standards within a minor object-classification showed graphic trends. Evaluation and Program Planning, for example, contained the greatest number of critical standards proportionately (73%) and absolutely (39). It was, in rank order, followed by Resident Training, Integration of the Multihandicapped, and Interdisciplinary Process Requirements. Each of these object-classifications evidenced 70% or more critical standards content. In absolute terms, Documentation, Habilitation Service, Rights of Residents, and Staffing requirements were ranked among the top five requirements.

Thirty-four standards were not complied with by at least 80% (28) of the facilities in the Non-Accredited Facilities Surveyed category. Nearly all (29) of the standards, so identified, fell into the major requirement of Provision of Active Habilitation Programming. Resident Training, Interdisciplinary Process, Documentation, and Evaluation and Program Planning requirements, respectively, contained the greatest proportions of critical standards among minor object-classifications. In near inverse order they ranked in the top four in absolute terms as well. One standard was not fully complied with by all 35 non-accredited facilities surveyed: "The number admitted as residents to the facility shall not exceed its provisions for adequate programming."

For Accredited Facilities Surveyed, five or more facilities did not comply with 39 standards. No standards in this facility category met an 80% criterion of significance. The median number of persons in residence was 92--considerably less than that for facilities not accredited. Proportions of critical standards content among major topical requirements ranged from a high of 15% for Provision of Services in a Normalizing Environment to a 0% for both Maintenance of a Safe and Sanitary Environment and Effective Administrative Practices.

In absolute terms, two-thirds of all critical standards (26, or 6%) were also specific to Provision of Active Habilitation Programming. The range of critical standards content within minor object-classifications was, proportionately, from 42% to 16% for Integration of the Multihandicapped, Physical Environment, Documentation, and Evaluation and Program Planning requirements, respectively. In absolute terms these same four classifications were ranked inversely and contained about two-thirds of all critical standards categorically identified.

A third facility category, All Facilities Surveyed consisted operationally of standards which fit into the non-accredited facilities surveyed category and also into the accredited facilities surveyed category. That is, if 14 or more facilities in the former category and also five or more facilities in the latter category did not comply with a standard, it was designated categorically critical. Thirty-seven standards met this criterion. These were the same standards identified as critical for accredited facilities surveyed. It followed, therefore, that the proportional and absolute rank orderings of major and minor object-classifications were nearly identical to those discovered among accredited facilities surveyed. If a standard was judged critical for accredited facilities, prohability was over 90% that it was also judged critical for non-accredited facilities surveyed, and therefore, for all facilities surveyed.

A summary of selected study findings specific to each facility category is shown in Table 10.

Table 10

Summary of Critical Deficiencies in Institutional Reform Vis-A-Vis Accreditation

Ranked--high to low--by proportions of standards in each area with which 40% or more of the facilities did not comply.	Ranked--high to low--by absolute number of standards in each area with which 40% or more of the facilities did not comply.
Critical Deficiencies Among Non-Accredited Facilities Surveyed	
1. Evaluation and Program Planning+	1. Evaluation and Program Planning+
2. Resident Training +	2. Documentation
3. Integration of the Multihandicapped	3. Habilitation Service
4. Interdisciplinary Process+	4. Rights of Residents
Critical Deficiencies Among Accredited Facilities Surveyed	
1. Integration of the Multihandicapped	1. Evaluation and Program Planning
2. Physical Environment	2. Documentation
3. Documentation	3. Physical Environment
4. Evaluation & Program Planning	4. Integration of the Multihandicapped
Critical Deficiencies Among All Facilities Surveyed	
1. Integration of the Multihandicapped	1. Evaluation and Program Planning
2. Documentation	2. Documentation
3. Physical Environment	3. Physical Environment
4. Evaluation & Program Planning	4. Integration of the Multihandicapped

+ Significant also at the 80% level.

Concluding Comment

As indicated in foregoing paragraphs, the major purpose of the Accreditation Standards Study was to analyze data emmanating from ACFMR surveys, and in doing so, to discover the most critical deficiencies in institutional reform, vis-a-vis accreditation. It is not surprising that the revealed deficiencies in institutional reform often appeared in such areas as Evaluation and Program Planning, Documentation, Resident Training, and Interdisciplinary Process requirements. This is so because, for the purposes of the study, the concept of "institutional reform" and the value orientation of the ACFMR standards were operationally synonomous. The explicit value orientation of the standards is weighted toward requiring that residents be prepared for community reintegration--not that they actually be reintegrated. Hence, the data show, especially for non-accredited facilities surveyed, substantial deficiencies in the Provision of Active Habilitation Programming to Each Resident and in its constituent subelements.

Community integration, however, is not a prime focus of the standards. It is the prime objective of deinstitutionalization (PCMR, 1974). The data, therefore, do not at this time lend themselves to the study of trends and deficiencies specific to deinstitutionalization. It is, however, interesting to note that facilities accredited were considerably smaller on the average than the facilities not accredited. The mean for accredited facilities surveyed was 92; it was 638 for non-accredited facilities surveyed. While this may be an empirical consequence of the survey process, the standards themselves do not require that a facility be small to be accredited. To illustrate, inspection of data furnished by the ACFMR on facility size showed that one facility with 796 residents was accredited and four facilities with less than 80 residents were not. The assumption that a facility must be small

to be accredited is false. It might be argued that smaller size makes it easier to implement the content of certain standards.

The data herein presented, particularly those specific to the 35 non-accredited facilities surveyed, provide some empirical evidence confirming the redundant charge that institutionalized mentally retarded people are victims of fundamental treatment inequities. Some of these basic abuses have been heretofore dramatized photographically (Blatt & Kaplan, 1974); and, in certain cases, affirmed by the judiciary (Wyatt vs. Stickney, 1972; Welsch vs. Likens, 1974). Recapitulating, substantial numbers of the non-accredited facilities did not comply with standards related to:

- The provision of habilitation or rehabilitation services based on individual needs;
- The use of interdisciplinary teams for initial and periodic evaluation, program planning, and review of resident's needs:
- The size of living unit components;
- The use of direct-care personnel in training residents in self-help skills such as bathing, menstrual care, grooming, and the use of money;
- The provision of comprehensive, interdisciplinary initial and periodic evaluation, program planning, and followup related to the individual resident's needs in education, rehabilitation, psychological services, and in speech pathology and audiology;
- The provision of educational programs to severely and profoundly retarded residents and to all other residents for whom educational provisions may not be required by state laws, irrespective of age or ability;
- The use of physical seclusion;[11]

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[11] The use of a directly monitored time-out room for not more than 15 minutes as a part of a behavior modification program meeting Applicable STANDARDS, SUCH AS PARENTAL CONSENT, IS NOT CONSIDERED TO be Seclusion.

- The excessive of chemical restraint;[12]
- The employment of sufficient, qualified personnel in direct-care service, dentistry, education, nursing, physical and occupational therapy, psychology, recreation, social services, speech pathology and audiology, and vocational training;
- The use of chronologically continuous program plan record for each resident, specifying goals and objectives in behavioral terms;
- The segregation of multihandicapped residents;
- The impersonal nature of the physical environment and respect for the privacy for residents in bathing and toileting, ownership of personal property, individual furniture and the like;
- The practice of peonage; and
- The observance of due process and other legal rights of residents at the age of majority and of certain rights for families of residents regarding involvement in planning, evaluation, and decision-making.

Substantial numbers of accredited facilities surveyed also did not comply with standards relating to:

- The size of living unit components;
- The use of appropriately constituted interdisciplinary teams for evaluating resident's needs and planning and individualized program;
- The admittance of residents who had not had a comprehensive evaluation;
- The requirements that there be individualized evaluation and program plans for each resident;
- The qualifications and number of direct-care staff;
- The use of chronologically continuous records for residents' evaluations, prognosis, program plans and progress;

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[12] The phrase "excessive use of chemical restraint" does not apply to the time-limited, physical prescribed use of drugs as a part of an individual program plan designed by an interdisciplinary team to lead to a less restrictive way of managing and ultimately eliminating behaviors for which drugs were employed. The resident's record must show that less restrictive methods have been tried uneffectively. Excessive use implies substitution of chemicals for staff or program.

- The existence of architectural barriers for multihandicapped residents;
- The impersonal nature of the physical environment, lack of privacy in bathing and toileting; and
- The observance of due process rights at the time the resident attains the age of majority.

Replication of this trend analysis study might profitably be conducted at regular intervals, e.g., annually. A basic and potentially continuing utility of the study has been to pull together, within a simple analytical framework, empirical baseline information with which to compare future data. As the on-site ACFMR survey data base increases, so does the generalizability of the findings and the consequent merit of such information for program planning purposes. Limitations of studying a nonrandom sample diminish as more facilities are surveyed.

The findings of the present study, however, bleakly suggest that many of the national goals of the 1960's (much less than those of the 1970's) vis-a-vis institutional reform have not been achieved--basic inequities persist. We are reminded of the remark attributed to Alexis DeTocqueville that abuses removed call increasing attention to the now more galling ones that remain. Trends revealed by the present study shed empirical light on some of the more persistent inequities in residential services to mentally retarded persons.

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APPENDICES

1 - Classified Critical Standards for 35 Non-Accredited Facilities Surveyed

2 - Classified Critical Standards for 13 Accredited Facilities Surveyed

3 - Classified Critical Standards for All Facilities Surveyed

4 - Sample Survey Data Sheet

5 - 651 Standards Classified According to Topical Requirements for Residential Facilities

Appendix 1

CLASSIFIED CRITICAL STANDARDS FOR 35 NON-ACCREDITED FACILITIES SURVEYED

(As asterisk adjacent to a standard number denotes that at least 80% of the non-accredited facilities surveyed did not comply with it. The actual number of non-accredited facilities not complying with a standard is shown parenthetically.)

I. Provision of Active Habilitation Programming to Each Resident

A. General Requirements

1.1.5.1 The grouping of program and residence units shall be based upon a rational plan to meet the needs of the residents and fulfill the purposes of the facility. (23)

* 1.3.1 No individual whose needs cannot be met by the facility shall be admitted to it. (34)

* 1.3.1.1.2 The number admitted as residents to the facility shall not exceed its provisions for adequate programming. (35)

2.1.1.1 Each resident shall receive appreciable and appropriate attention each day from the staff in the living unit. (14)

2.1.1.4 Appropriate provisions shall be made to ensure that the efforts of the staff are not diverted to excessive housekeeping and clerical duties, or other non-resident-care activities. (16)

2.5.1 Living unit components or groupings shall be small enough to ensure the development of meaningful interpersonal relationships among residents and between residents and staff. (26)

* 3.15.1 The facility shall provide all its residents with habilitation or rehabilitation services, which includes the establishment, maintenance, and implementation of those programs that will ensure the optimal development or restoration of each resident, physically, psychologically, socially, and vocationally. (33)

B. Interdisciplinary Process Requirements

* 3.1.2.1 Interdisciplinary teams for evaluating the resident's needs, planning an individualized habilitation program to meet identified needs, and periodically reviewing the resident's response to his program and revising the program accordingly, shall be constituted of persons drawn from, or representing, such of the professions, disciplines, or service areas as are relevant in each particular case. (33)

* 3.1.2.3 Regardless of the means by which the facility makes professional services available to its residents, there shall be evidence that members of professional disciplines work together in cooperative, coordinated, interdisciplinary fashion to achieve the objectives of the facility. (29)

3.3.3.1 Where appropriate, an educator shall be a member of the interdisciplinary teams or groups concerned with the total programming of each resident. (14)

3.6.5.1 Physicians shall participate, when appropriate, in the continuing interdisciplinary evaluation of individual residents, for the purposes of initiation, monitoring, and follow-up of individualized habilitation programs. (22)

3.9.4.4 Physical therapists shall participate, when appropriate, in the continuing interdisciplinary evaluation of individual residents, for the purposes of initiation, monitoring, and follow-up of individualized habilitation programs. (16)

3.10.3 Psychologists shall participate, when appropriate, in the continuing interdisciplinary evaluation of individual residents, for the purposes of initiation, monitoring, and follow-up of individualized habilitation programs. (15)

3.11.9 Recreation services shall be coordinated with other services and programs provided the residents, in order to make fullest possible use of the facility's resources and to maximize benefits to the residents. (14)

C. Evaluation and Program Planning Requirements

1.3.3 The residential facility shall admit only residents who have had a comprehensive evaluation, covering physical, emotional, social, and cognitive factors, conducted by an appropriately constituted interdisciplinary team. (27)

1.3.3.2 All available and applicable programs of care, treatment, and training shall be investigated and weighed, and the deliberations and findings recorded. (20)

1.3.3.3 Admission to the residential facility shall occur only when it is determined to be the optimal available plan. (23)

1.3.3.6 All admissions to the residential facility shall be considered temporary, and admissions shall be time-limited when appropriate. (24)

1.3.5.1 Within the period of one month after admission there shall be a review and updating of the preadmission evaluation. (23)

1.3.5.2 Within the period of one month after admission there shall be a prognosis that can be used for programming and placement. (33)

* 1.3.5.3 Within the period of one month after admission there shall be a comprehensive evaluation and individual program plan, made by an interdisciplinary team. (34)

* 1.3.5.6.1 An interpretation of the comprehensive evaluation, in action terms, shall be made to the direct-care personnel responsible for carrying out the resident's program. (30)

* 1.3.5.6.2 An interpretation of the comprehensive evaluation, in action terms, shall be made to the special services staff responsible for carrying out the resident's program. (31)

* 1.3.6 There shall be a regular, at least annual, joint review of the status of each resident by all relevant personnel, including personnel in the living unit, with program recommendations for implementation. (28)

1.3.6.1 This review shall include consideration of the advisability of continued residence and alternative programs. (24)

1.3.6.3.1 The results of these reviews shall be recorded in the resident's unit record. (14)

* 2.1.2.1 There shall be specific evaluation and program plans for each resident that are: (32)

2.1.2.1.1 Available to direct care staff in each living unit. (27)

* 2.2.2.1.1 Modified diets shall be prescribed by the resident's program team, with a record of the prescription kept on file. (29)

2.2.2.1.3 Modified diets shall be periodically reviewed and a[illegible]ed as needed. (21)

2.2.4.1 Residents with special eating disabilities shall be provided with an interdisciplinary approach to the diagnosis and remediation of their problems, consistent with their developmental needs. (19)

3.3.4.1 Individual educational evaluations of residents shall comm[illegible]ce with the admission of the resident. (23)

3.3.4.2 Individual educational evaluations of residents shall be conducted at least annually. (21)

3.3.4.4 Individual educational evaluations of residents shall provide the basis for prescribing an appropriate program of learning experiences for the resident. (14)

3.3.4.5 Individual educational evaluations of residents shall provide the basis for revising the individual prescription as needed. (18)

3.3.4.6.2 The reporting and dissemination of evaluation results shall be done in such a manner as to promptly provide information useful to staff working directly with the resident. (19)

3.3.5 There shall be written educational objectives for each resident. (22)

3.3.6 There shall be evidence of educational activities designed to meet the educational objectives set for every resident. (22)

3.4.3.1 Whenever appropriate, the following services should be provided: Initial and periodic evaluation of the nutritional status of each resident. (21)

3.6.6.1 The management plan shall ordinarily include, but not necessarily be limited to the resident's day-to-day activity program. (17)

3.6.6.2 The management plan shall ordinarily include, but not necessarily be limited to physical rehabilitation to prevent and correct deformity, to enhance mobility, and to facilitate training in self-help skills. (16)

3.6.6.3 The management plan shall ordinarily include, but not necessarily be limited to provision for adaptive equipment necessary to the rehabilitation plan. (15)

3.6.6.6 " " " " " " "
" " " " Stated intervals for review of the management plan. (14)

3.6.6.7 " " " " " " "
" " " " Short- and long-term goals, including criteria for release. (19)

3.6.7.1 Statement of treatment goals and management plans shall be reviewed and updated as needed, but at least annually. (14)

3.6.7.2 " " " " " "
" " " to ensure continuing appropriateness of the goals, consistency of management methods with the goals, and the achievement of progress toward the goals. (15)

3.10.2.1 Psychological services available to the residential facility should include evaluation and assessment of individuals and programs. (15)

3.10.3.4.1 The reporting and dissemination of evaluation results shall be done in such a manner as to render the content of the report meaningful and useful to its intended recipient and user. (18)

* 3.10.4 Psychologists shall participate, when appropriate, in the development of written, detailed, specific, and individualized habilitation program plans that: (31)

3.10.4.1 Provide for periodic review, follow-up and updating. (27)

* 3.10.4.2 Are designed to maximize each resident's development and acquisition of living skills. (30)

3.14.4.1.1 Speech pathology and audiology services available to the facility shall include, as appropriate, audiometric screening of all new residents. (18)

3.14.4.2.1 Speech pathology and audiology services available to the facility shall include, as appropriate, speech and language screening of all new residents. (18)

D. Management of Program Delivery Requirements

* 2.1.2.1.2 There shall be specific evaluation and program plans for each resident that are reviewed by a member or members of the interdisciplinary program team at least monthly, with documentation of such review entered in the resident's record. (32)

2.1.2.2 Activity schedules for each resident shall be available to direct care staff and shall be implemented daily. (19)

2.5.3 The living unit shall not be a self-contained program unit, and living unit activities shall be coordinated with recreation, educational, and habilitative activities in which residents engage outside the living unit, unless contraindicated by the specific program needs of the particular residents being served. (19)

E. Resident Training Requirements

* 2.1.1.2 Living unit personnel shall train residents in activities of daily living and in the development of self-help and social skills. (31)

2.1.5 Residents should be instructed in the free and unsupervised use of communication processes. (25)

2.1.7.1.2 In accordance with their developmental level, residents shall be trained in the value and use of money. (23)

2.3.3 Storage space for clothing to which the resident has access shall be provided. (25)

* 2.4.1.1 Each resident shall be assisted in learning normal grooming practices with individual toilet articles that are appropriately available to that resident. (29)

* 2.4.1.5.1 Resident's bathing shall be conducted at the most independent level possible. (29)

2.4.1.6 Female residents shall be helped to attain maximum independence in caring for menstrual needs. (27)

2.4.2.1 The facility's training program shall be applied systematically and regularly. (23)

3.3.7.3 Educational programs shall be provided severely and profoundly retarded residents, and all other residents for whom educational provisions may not be required by state laws, irrespective of age or ability. (24)

3.3.7.4 Appropriate educational programs shall be provided residents with hearing, vision, perceptual, and/or motor impairments, in cooperation with appropriate staff. (18)

F. Behavior Management Requirements

2.1.8 There shall be provision for prompt recognition and appropriate management of behavioral problems in the living unit. (27)

2.1.8.1 There shall be a written statement of policies and procedures for the control and discipline of residents that is: (14)

2.1.8.1.1 Directed to the goal of maximizing the growth and development of the residents. (26)

2.1.8.1.2 Available in each living unit. (17)

2.1.8.5 Seclusion, defined as the placement of a resident alone in a locked room, shall not be employed. (26)

2.1.8.6.1.1 Orders for restraints shall not be in force for longer than 12 hours. (22)

2.1.8.6.1.1.1 Standing or PRN orders for restraint shall not be used. (20)

2.1.8.6.2 Totally enclosed cribs and barred enclosures shall be considered restraints. (18)

2.1.8.8 Chemical restraint shall not be used excessively, as punishment, for the convenience of staff, as a substitute for program or in quantities that interfere with a resident's habilitation program. (22)

2.1.8.9.5 Removal from a situation for time-out purposes shall not be for more than one hour, and this procedure shall be used only during the conditioning program, and only under the supervision of the trainer. (16)

G. Attention to Resident Health Needs Requirements

2.1.8.7.2 Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be restraints, but shall be designed and applied so as to reflect concern for principles of good body alignment, concern for circulation, and allowance for change of position. (14)

2.4.4.3 Procedures shall be established for maintenance of weight and height records. (18)

3.7.4.3 Nursing services to residents shall include, when appropriate: participation in the prevention of disability for all residents, with special attention to those residents who exhibit the lowest level of functional development. (16)

3.8.4.2 The pharmacist should regularly review the record of each resident on medication, and have contact with selected residents' with potential problems, noting in the residents' records and reporting to physicians any observations of response to drug therapy, and of adverse reactions and over-or under-utilization or drugs. (27)

H. Habilitation Service Requirements

* 3.1.1 Residents shall be provided with the professional and special programs and services in accordance with their needs for such programs and services. (30)

* 3.1.3.1 Programs and services and the pattern of staff organization and function within the facility shall be focused upon serving the individual needs of residents and should provide for comprehensive diagnosis and evaluation of each resident as a basis for planning programming and management. (30)

* 3.1.3.2 " " " " " " "
" " " " " " "
" " " " " " "
" " " design and implementation of an individualized habilitation program to effectively meet the needs of each resident. (29)

3.1.3.3 " " " " " " "
" " " " " " "
" " " " " " "
" " " regular review, evaluation, and revision, as necessary, of each individual's habilitation program. (27)

3.3.1 Educational services, defined as deliberate attempts to facilitate the intellectual, sensorimotor, and affective development of the individual, shall be available to all residents, regardless of chronological age, degree of retardation, or accompanying disabilities or handicaps. (25)

3.5.1 Library services, which include the location, acquisition, organization, utilization, retrieval, and delivery of materials in a variety of media, shall be available to the facility, in order to support and strengthen its total habilitation program by providing complete and integrated multi-media information services to both staff and residents. (19)

3.9.1.1 Physical therapy services shall be provided in order to: (16)

3.9.1.1.1 Prevent abnormal development and further disability. (19)

3.9.1.1.2 Facilitate the optimal development of each resident. (23)

3.9.1.1.3 Enable the resident to be a contributing and participating member of the community in which he resides. (15)

3.10.1 Psychological services shall be provided, in order to facilitate, through the application of psychological principles, techniques, and skills, the optimal development of each resident. (27)

* 3.10.9.1 There shall be available sufficient, appropriately qualified staff, and necessary supporting personnel, to carry out the various psychological services to residents, including evaluation, consultation, therapy, and program development. (28)

3.11.1 Recreation services should provide each resident with a program of activities. (17)

3.14.1 Speech pathology and audiology services shall be available. (25)

3.15.8 Vocational training programs shall meet all applicable legal requirements. (19)

I. Staff Training and Consultation Requirements

1.4.7 Appropriate to the size and nature of the facility, there shall be a staff training program that includes: (17)

1.4.7.2 Induction training for each new employee, so that his skills in working with the residents are increased. (15)

3.9.1.3.2 Physical therapy services shall be provided indirectly, through contact between therapists and other persons involved with the residents. (14)

3.10.1.1.1 Psychological services shall be rendered directly, through personal contact between psychologists and residents. (16)

* 3.10.1.1.2 Psychological services shall be rendered indirectly, through contact between psychologists and other persons involved with the residents. (28)

J. Staffing Requirements

2.6.1 There shall be sufficient, appropriately qualified, and adequately trained personnel to conduct the resident-living

2.6.1 (cont'd) program, in accordance with the Standards for Residential Facilities for the Mentally Retarded, 1974. (26)

3.2.11 There shall be available sufficient, appropriately qualified dental personnel, and necessary supporting staff, to carry out the dental services program. (18)

3.3.8 There shall be available sufficient, appropriately qualified educational personnel, and necessary supporting staff, to carry out the educational programs. (24)

3.7.7 There shall be available sufficient, appropriately qualified nursing staff, which may include currently licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. (18)

3.9.8 There shall be available sufficient, appropriately qualified staff, and supporting personnel, to carry out the various physical and occupational therapy services. (17)

* 3.10.9 There shall be available sufficient, appropriately qualified staff, and necessary supporting personnel, to carry out the various psychological service activities. (31)

3.11.12 There shall be sufficient, appropriately qualified recreation staff, and necessary supporting staff, to carry out the various recreation services. (21)

3.13.13 There shall be available sufficient, appropriately qualified staff and necessary supporting personnel to carry out the various social service activities. (16)

3.14.10 There shall be available sufficient, appropriately qualified staff, and necessary supporting personnel, to carry out the various speech pathology and audiology services. (24)

3.15.8.8 Facilities conducting vocational training programs shall have vocational training personnel assigned, in such numbers and for such times as are necessary and appropriate to the situation, to supervise the training in each training area. (20)

K. Documentation Requirements

1.3.5.5 The results of the evaluation shall be recorded in the resident's unit record. (24)

* 4.1.1.1 There shall be for each resident a chronologically continuous record that documents an evaluation that identifies the specific developmental needs of the resident. (28)

* 4.1.1.2 There shall be for each resident a chronologically continuous record that specifies the habilitation program plan devised to meet the identified needs, with program goals stated in the behavioral terms. (32)

* 4.1.1.3 There shall be for each resident a chronologically continuous record that reports the response of the resident to the plan, and his progress toward the goals. (29)

* 4.1.1.4 There shall be for each resident a chronologically continuous record that documents review and modification of the program plan and goals in the light of the resident's response. (31)

4.1.2 Pertinent information shall be incorporated in the resident's record, in sufficient detail to enable those persons involved in the resident's program to provide effective, continuing services. (23)

4.1.3.3 All entries in the resident's record shall be authenticated by the signature and identification of the individual making the entry. (16)

4.2.1.12 Report(s) of the preadmission evaluation(s) should be obtained and entered in the resident's record at the time of admission to the facility. (18)

4.2.2 Within the period of one month after admission there shall be entered in the resident's record: (18)

4.2.2.1 A report of the review and up-dating of the preadmission evaluation; (24)

* 4.2.2.2 A statement of prognosis that can be used for programming and placement; (33)

* 4.2.2.3 A comprehensive evaluation and individual program plan, designed by an interdisciplinary team. (33)

4.2.3.3 Records during residence should include report of regular, at least annual, review and evaluation of the program, developmental progress, and status of each resident. (18)

4.2.3.4 Records during residence should include observations of the resident's response to his program, recorded with sufficient frequency to enable evaluation of its effiacy. (26)

4.2.4.1 At the time of discharge from the facility, a discharge summary shall be prepared that should include a brief recapitulation of findings, events, and progress during residence, diagnosis, prognosis, and recommendations and arrangements for future programming. (14)

L. Facilities and Equipment Requirements

2.7.5 Toilet areas, clothes closets, and other facilities shall be equipped so as to facilitate training toward maximum self-help by residents, including the severely and profoundly retarded and the multiply-handicapped. (27)

3.11.17 Adequate transportation services for recreation programs shall be provided. (15)

II. Provision of Services within a Normalized and Normalizing Environment

A. General Normalization Requirements

* 1.1.1.1 The facility shall accept and implement the principle of normalization, defined as the use of means that are as culturally normative as possible to elicit and maintain behavior that is as culturally normative as possible, taking into account local and subcultural differences. (28)

2.1.1.3 Living unit personnel shall be responsible for the development and maintenance of a warm, family- or home-like environment that is conducive to the achievement of optimal development by the resident. (21)

2.2.2.7.4 Food shall be served at appropriate temperature. (15)

2.3.1 Each resident shall have an adequate allowance of neat, clean, fashionable, and seasonable clothing. (16)

2.3.1.1 Each resident shall have his own clothing, which is, when necessary, properly (inconspicuously) marked with his name, and he shall use this clothing. (17)

2.3.1.3 Nonambulatory residents shall be dressed daily in their own clothing, including shoes, unless contradicted in written medical orders. (17)

2.4.1.6.1 Menstrual supplies shall be of the same quality and diversity available to all women. (24)

B. Community Integration Requirements

3.1.1.2 In accordance with the normalization principle, all professional services to the retarded should be rendered

3.1.1.2 (cont'd.) in the community, whenever possible, rather than in a residential facility, and where rendered in a residential facility, such services must be at least comparable to those provided the non-retarded in the community. (17)

C. Integration of Multi-Handicapped Requirements

2.4.3.3 There shall be a drinking unit accessible to, and usable by, residents in wheelchairs. (22)

2.5.2.2 Residents who are mobile-nonambulatory, deaf, blind, epileptic, etc., shall be integrated with peers of comparable social and intellectual development, and shall not be segregated on the basis of their handicaps. (22)

* 2.7.5.3 Water closets and bathing and toileting appliances shall be equipped for use by the physically handicapped. (28)

2.7.5.4.1 At least one water closet in each living unit shall be accessible to residents in wheelchairs. (26)

2.7.5.5.1 At least one lavatory shall be accessible to, and usable by, residents in wheelchairs. (21)

D. Rhythm of Life Requirements

2.1.3 The "rhythm of life" in the living unit shall resemble the cultural norm for the residents' nonretarded age peers, unless a departure from this rhythm is justified on the basis of maximizing the residents' human qualities. (22)

2.1.3.2.3 Multiply handicapped and nonambulatory residents shall have planned daily activity and exercise periods. (16)

2.1.3.3 All residents shall have planned periods out of doors on a year-round basis. (18)

E. Physical Environment Requirements

2.2.3 All residents, including the mobile nonambulatory, shall eat or be fed in dining rooms, except where contraindicated for health reasons, or by decision of the team responsible for the resident's program. (14)

2.4.1.5.2 Residents' bathing shall be conducted with due regard for privacy. (25)

2.5.4 Residents shall be allowed free use of all living areas within the living unit, with due regard for privacy and personal possessions. (26)

* 2.7.2.3 Furniture and furnishings shall be safe, appropriate, comfortable, and home-like. (30)

2.7.3.8.1 A separate bed of proper size and height for the convenience of the resident shall be provided. (15)

* 2.7.3.9.1 Each resident shall be provided with appropriate individual furniture, such as a chest of drawers, a table or desk, and an individual closet with clothes racks and shelves accessible to the resident. (29)

2.7.3.9.2 Each resident shall be provided with a place of his own for personal play equipment and/or individually prescribed prosthetic equipment. (26)

2.7.5.2 Toilets, bathtubs, and showers shall provide for individual privacy (with partitions and doors), unless specifically contraindicated by program needs. (26)

2.7.5.4.2 Each water closet shall be equipped with a toilet seat. (15)

2.7.5.4.3 Toilet tissue shall be readily accessible at each water closet. (23)

III. Assurance of the Rights of Residents and their Families

A. General Rights Assurances Requirements

None

B. Rights of Resident Requirements

1.3.6.2.1 At the time of the resident's attaining majority, or if he becomes emancipated prior thereto, the review shall include consideration of the resident's need for remaining in the facility. (20)

1.3.6.2.2 " " " "
" " " "
" " " the need for guardianship of the resident. (21)

1.3.6.2.3 " " " "
" " " "
" " " the exercise of the resident's civil and legal rights. (23)

1.3.6.3.4 The results of the reviews shall be interpreted to the resident, when appropriate. (23)

1.3.8.3.1 There shall be written evidence that the reason for a resident transfer is the welfare of the resident. (16)

1.4.6 Staffing shall be sufficient so that the facility is not dependent upon the use of residents or volunteers for productive services. (15)

1.4.6.4.2 Residents who function at the level of staff in occupational or training activities shall be paid at the legally required wage level when employed in other than training situations. (20)

2.1.5.1 Residents should be instructed in the free and unsupervised use of communication processes. Except as denied individual residents by team action, for cause, this should typically include having access to telephones for incoming and local out-going calls. (19)

2.1.5.3 " " " " "
" " " " "
" " " " "
" " " opening their own mail and packages, and generally doing so without direct surveillance. (17)

2.1.8.9.1 Behavior modification programs involving the use of time-out devices or the use of noxious or aversive stimuli shall be reviewed and approved by the facility's research review and human rights committees. (22)

3.12.6.1 Those who serve the religious needs of the residents, including clergy, religious educators, and volunteers, should assert and safeguard the full human and civil rights of the residents. (19)

C. Rights of Families Requirements

* 1.3.5.6.3 An interpretation of the comprehensive evaluation, in action terms, shall be made to the resident's parents or their surrogates. (30)

1.3.6.3.3 The results of resident's reviews shall be interpreted to the resident's parents or surrogates. (22)

1.3.6.4 Parents or their surrogates shall be involved in planning and decision making. (21)

2.1.8.1.3 There shall be a written statement of policies and procedures for the control and discipline of residents that is available to parents or guardians. (17)

2.1.8.9.2 Behavior modification programs involving the use of time-out devices or the use of noxious or aversive stimuli shall be conducted only with the consent of the affected resident's parents or surrogates. (17)

IV. Effective Administrative Practices

A. General Administrative Requirements

3.1.3 Programs and services and the pattern of staff organization and function within the facility shall be focused upon serving the individual needs of residents. (23)

B. Communication Requirements

1.2.8.4 The administration of the facility shall provide for effective staff and resident participation and communication. (14)

C. Records Requirements

4.1.1.7 There shall be for each resident a chronologically continuous record that furnishes a basis for review, study, and evaluation of the overall programs provided by the facility, and the staff. (22)

4.4.1.1 There shall be a unit record that contains all information pertaining to an individual resident for all admissions to the facility. (15)

D. Research Requirements

None

V. Maintenance of a Safe and Sanitary Environment

2.7.6.5 The temperature of the hot water at all taps to which residents have access shall be controlled, by the use of thermostatically controlled mixing valves or by other means, so that it does not exceed 110 degrees Fahrenheit. (19)

2.7.6.6 Emergency lighting of stairs and exits, with automatic switches, shall be provided in units housing more than 15 residents. (15)

6.1.1 The requirements of the National Fire Protection Association Life Safety Code, 1970 Edition, shall be met, with specific reference to: (21)

6.1.1.2 Provision of exit ramps, with nonskid surface and slope not exceeding one foot in twelve. (17)

6.1.4 Evacuation drills shall be held at least quarterly, for each shift of facility personnel and under varied conditions, in order to: (17)

6.1.4.1 Ensure that all personnel on all shifts are trained to perform assigned tasks; (14)

6.1.4.2 Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility. (16)

CLASSIFIED CRITICAL STANDARDS FOR 13 ACCREDITED FACILITIES SURVEYED

(The actual number of facilities not complying with a standard is shown parenthetically)

I. Provision of Active Habilitation Programming to Each Resident

A. General Requirements

2.5.1 Living unit components or groupings shall be small enough to ensure the development of meaningful interpersonal relationships among residents and between residents and staff. (5)

3.15.1 The facility shall provide all its residents with habilitation or rehabilitation services, which includes the establishment, maintenance, and implementation of those programs that will ensure the optimal development or restoration of each resident, physically, psychologically, socially, and vocationally. (5)

B. Interdisciplinary Process Requirements

3.1.2.1 Interdisciplinary teams for evaluating the resident's needs, planning an individualized habilitation program to meet identified needs, and periodically reviewing the resident's response to his program and revising the program accordingly, shall be constituted of persons drawn from, or representing, such of the professions, disciplines, or service areas as are relevant in each particular case. (6)

C. Evaluation and Program Planning Requirements

1.3.3 The residential facility shall admit only residents who have had a comprehensive evaluation, covering physical, emotional, social, and cognitive factors, conducted by an appropriately constituted interdisciplinary team. (6)

1.3.3.2 All available and applicable programs of care, treatment, and training, shall be investigated and weighed, and the deliberations and findings recorded. (6)

1.3.3.6 All admissions to the residential facility shall be considered temporary, and admissions shall be time-limited when appropriate. (5)

1.3.5.1 Within the period of one month after admission there shall be a review and updating of the preadmission evaluation. (5)

1.3.5.2 Within the period of one month after admission there shall be a prognosis that can be used for programming and placement. (8)

1.3.5.3 Within the period of one month after admission there shall be a comprehensive evaluation and individual program plan, made by an interdisciplinary team. (7)

2.1.2.1 There shall be specific evaluation and program plans for each resident. (9)

2.2.2.1.1 Modified diets shall be prescribed the the resident's program team, with a record of the prescription kept on file. (8)

2.2.2.1.3 Modified diets shall be periodically reviewed and adjusted as needed. (5)

D. Management of Program Delivery Requirements

2.1.2.1.2 There shall be specific evaluation and program plans for each resident that are reviewed by a member or members of the interdisciplinary program team at least monthly, with documentation of such review entered in the resident's record. (5)

E. Resident Training Requirements

2.3.3 Storage space for clothing to which the resident has access shall be provided. (6)

2.4.1.6 Female residents shall be helped to attain maximum independence in caring for menstrual needs. (5)

F. Behavior Management Requirements

None

G. Attention to Resident Health Needs Requirements

3.8.4.2 The pharmacist should regularly review the record of each resident on medication, and have contact with selected residents with potential problems, noting in the residents' records and reporting to physicians any observations of response to drug therapy, and of adverse reactions and over- or under-utilization of drugs. (7)

3.8.6.3.4 No medication shall be administered to a resident without a written order by a physician. (5)

H. Habilitation Services Requirements

None

I. Staff Training and Consultation Requirements

None

J. Staffing Requirements

2.6.1 There shall be sufficient, appropriately qualified, and adequately trained personnel to conduct the resident-living program, in accordance with the Standards for Residential Facilities for the Mentally Retarded, 1974. (6)

K. Documentation Requirements

4.1.1.2	There shall be for each resident a chronologically continuous record that specifies the habilitation program plan devised to meet the identified needs, with program goals stated in behavioral terms. (6)
4.1.1.3	There shall be for each resident a chronologically continuous record that reports the response of the resident to the plan, and his progress toward the goals. (6)
4.1.1.4	There shall be for each resident a chronologically continuous record that documents review and modification of the program plan and goals in the light of the resident's response. (5)
4.1.2	Pertinent information shall be incorporated in the resident's record, in sufficient detail to enable those persons involved in the resident's program to provide effective, continuing services. (5)
4.2.1.12	Report(s) of the preadmission evaluation(s) should be obtained and entered in the resident's record at the time of admission to the facility. (7)
4.2.2.2	Within the period of one month after admission there shall be entered in the resident's record a statement of prognosis that can be used for programming and placement. (7)
4.2.2.3	Within the period of one month after admission there shall be entered in the resident's record a comprehensive evaluation and individual program plan, designed by an interdisciplinary team. (6)
4.2.3.4	Records during residence should include observations of the resident's response to his program, recorded with sufficient frequency to enable evaluation of its efficacy. (6)

L. Facilities and Equipment Requirements

2.7.5	Toilet areas, clothes closets, and other facilities shall be located and equipped so as to facilitate training toward maximum self-help by residents, including the severely and profoundly retarded and the multiply-handicapped. (6)

II. Provision of Services Within a Normalized and Normalizing Environment

A. General Normalization Requirements

2.4.1.6.1 Menstrual supplies shall be of the same quality and diversity available to all women. (7)

B. Community Integration Requirements

None

C. Integration of Multihandicapped Requirements

2.4.3.3 There shall be a drinking unit accessible to, and usable by, residents in wheelchairs. (7)

2.7.5.3 Water closets and bathing and toileting appliances shall be equipped for use by the physically handicapped. (8)

2.7.5.4.1 At least one water closet in each living unit shall be accessible to residents in wheelchairs. (6)

D. Rhythm of Life Requirements

None

E. Physical Environment Requirements

2.4.3 Each living unit shall have a properly adapted drinking unit. (5)

2.7.2.3 Furniture and furnishings shall be safe, appropriate, comfortable, and home-like. (6)

2.7.3.9.1 Each resident shall be provided with appropriate individual furniture, such as a chest of drawers, a table or desk, and an individual closet with clothes racks and shelves accessible to the resident. (8)

2.7.3.9.2 Each resident shall be provided with a place of his own for personal play equipment and/or individually prescribed prosthetic equipment. (5)

2.7.5.2 Toilets, bathtubs, and showers shall provide for individual privacy (with partitions and doors), unless specifically contraindicated by program needs. (7)

III. Assurance of Rights of Residents and Their Families

A. General Rights Assurances Requirements

None

B. Rights of Residents Requirements

1.3.6.2.3 At the time of the resident's attaining majority, or if he becomes emancipated prior thereto, the review shall include consideration of the exercise of the resident's civil and legal rights. (5)

2.1.8.9.1 Behavior modification programs involving the use of time-out devices or the use of noxious or aversive stimuli shall be reviewed and approved by the facility's research review and human rights committees. (8)

C. Rights of Families Requirements

1.3.5.6.3 An interpretation of the evaluation, in action terms, shall be made to the resident's parents or their surrogates. (5)

IV. Effective Administrative Practices

A. General Administrative Requirements

None

B. Communication Requirements

None

C. Records Requirements

None

D. Research Requirements

None

V. Maintenance of a Safe and Sanitary Environment

None

Appendix 3

CLASSIFIED CRITICAL STANDARDS FOR ALL FACILITIES SURVEYED

(The actual number of non-accredited facilities surveyed not complying with a standard appears first, parenthetically; then, follows the number of accredited facilities not in compliance)

I. Provision of Active Habilitation Programming to Each Resident

A. General Requirements

2.5.1 Living unit components or groupings shall be small enough to ensure the development of meaningful interpersonal relationships among residents and between residents and staff. (26) (5)

3.15.1 The facility shall provide all its residents with habilitation or rehabilitation services, which includes the establishment, maintenance, and implementation of those programs that will ensure the optimal development or restoration of each resident, physically, psychologically, socially, and vocationally. (33) (5)

B. Interdisciplinary Process Requirements

3.1.2.1 Interdisciplinary teams for evaluating the resident's needs, planning an individualized habilitation program to meet identified needs, and periodically reviewing the resident's response to his program and revising the program accordingly, shall be constituted of persons drawn from, or representing, such of the professions, disciplines, or service areas as are relevant in each particular case. (33) (6)

C. Evaluation and Program Planning Requirements

1.3.3 The residential facility shall admit only residents who have had a comprehensive evaluation, covering physical, emotional, social, and cognitive factors, conducted by an appropriately constituted interdisciplinary team. (27) (6)

1.3.3.2 All available and applicable programs of care, treatment, and training, shall be investigated and weighed, and the deliberations and findings recorded. (20) (6)

1.3.3.6 All admissions to the residential facility shall be considered temporary, and admissions shall be time-limited when appropriate. (24) (5)

1.3.5.1 Within the period of one month after admission there shall be a review and updating of the preadmission evaluation. (23) (5)

1.3.5.2 Within the period of one month after admission there shall be a prognosis that can be used for programming and placement. (33) (8)

1.3.5.3 Within the period of one month after admission there shall be a comprehensive evaluation and individual program plan, made by an interdisciplinary team. (34) (7)

2.1.2.1 There shall be specific evaluation and program plans for each resident. (32) (9)

2.2.2.1.1 Modified diets shall be prescribed the the resident's program team, with a record of the prescription kept on file. (29) (8)

2.2.2.1.3 Modified diets shall be periodically reviewed and adjusted as needed. (21) (5)

D. Management of Program Delivery Requirements

2.1.2.1.2 There shall be specific evaluation and program plans for each resident that are reviewed by a member or members of the interdisciplinary program team at least monthly, with documentation of such review entered in the resident's record. (32) (5)

E. Resident Training Requirements

2.3.3 Storage space for clothing to which the resident has access shall be provided. (25) (6)

2.4.1.6 Female residents shall be helped to attain maximum independence in caring for menstrual needs. (27) (5)

F. Behavior Management Requirements

None

G. Attention to Resident Health Needs Requirements

3.8.4.2 The pharmacist should regularly review the record of each resident on medication, and have contact with selected residents with potential problems, noting in the residents' records and reporting to physicians any observations of response to drug therapy, and of adverse reactions and over- or under-utilization of drugs. (27) (7)

H. Habilitation Services Requirements

None

I. Staff Training and Consultation Requirements

None

J. Staffing Requirements

2.6.1 There shall be sufficient, appropriately qualified, and adequately trained personnel to conduct the resident-living program, in accordance with the Standards for Residential Facilities for the Mentally Retarded, 1974. (26) (6)

K. Documentation Requirements

4.1.1.2 There shall be for each resident a chronologically continuous record that specifies the habilitation program plan devised to meet the identified needs, with program goals stated in behavioral terms. (32) (6)

4.1.1.3 There shall be for each resident a chronologically continuous record that reports the response of the resident to the plan, and his progress toward the goals. (29) (6)

4.1.1.4 There shall be for each resident a chronologically continuous record that documents review and modification of the program plan and goals in the light of the resident's response. (31) (5)

4.1.2 Pertinent information shall be incorporated in the resident's record, in sufficient detail to enable those persons involved in the resident's program to provide effective, continuing services. (23) (5)

4.2.1.12 Report(s) of the preadmission evaluation(s) should be obtained and entered in the resident's record at the time of admission to the facility. (18) (7)

4.2.2.2 Within the period of one month after admission there shall be entered in the resident's record a statement of prognosis that can be used for programming and placement. (33) (7)

4.2.2.3-1 Within the period of one month after admission there shall be entered in the resident's record a comprehensive evaluation and individual program plan, designed by an interdisciplinary team. (33) (6)

4.2.3.4 Records during residence should include observations of the resident's response to his program, recorded with sufficient frequency to enable evaluation of its efficacy. (26) (6)

L. Facilities and Equipment Requirements

2.7.5 Toilet areas, clothes closets, and other facilities shall be located and equipped so as to facilitate training toward maximum self-help by residents, including the severely and profoundly retarded and the multiply-handicapped. (27) (6)

II. Provision of Services Within a Normalized and Normalizing Environment

A. General Normalization Requirements

2.4.1.6.1 Menstrual supplies shall be of the same quality and diversity available to all women. (27) (5)

B. Community Integration Requirements

None

C. Integration of Multihandicapped Requirements

2.4.3.3 There shall be a drinking unit accessible to, and usable by, residents in wheelchairs. (22) (7)

2.7.5.3 Water closets and bathing and toileting appliances shall be equipped for use by the physically handicapped. (28) (8)

2.7.5.4.1 At least one water closet in each living unit shall be accessible to residents in wheelchairs. (26) (6)

D. Rhythm of Life Requirements

None

E. Physical Environment Requirements

2.7.2.3 Furniture and furnishings shall be safe, appropriate, comfortable, and home-like. (30) (6)

2.7.3.9.1 Each resident shall be provided with appropriate individual furniture, such as a chest of drawers, a table or desk, and an individual closet with clothes racks and shelves accessible to the resident. (29) (8)

2.7.3.9.2 Each resident shall be provided with a place of his own for personal play equipment and/or individually prescribed prosthetic equipment. (26) (5)

2.7.5.2 Toilets, bathtubs, and showers shall provide for individual privacy (with partitions and doors), unless specifically contraindicated by program needs. (26) (7)

III. Assurance of Rights of Residents and Their Families

A. General Rights Assurances Requirements

None

B. Rights of Residents Requirements

1.3.6.2.3 At the time of the resident's attaining majority, or if he becomes emancipated prior thereto, the review shall include consideration of the exercise of the resident's civil and legal rights. (23) (5)

2.1.8.9.1 Behavior modification programs involving the use of time-out devices or the use of noxious or aversive stimuli shall be reviewed and approved by the facility's research review and human rights committees. (22) (8)

C. Rights of Families Requirements

1.3.5.6.3 An interpretation of the evaluation, in action terms, shall be made to the resident's parents or their surrogates. (30) (5)

IV. Effective Administrative Practices

A. General Administrative Requirements

None

B. Communication Requirements

None

C. Records Requirements

None

D. Research Requirements

None

V. Maintenance of a Safe and Sanitary Environment

None

Appendix 4

SAMPLE SURVEY DATA SHEET

Standard Number	Content	* N	** A
1.4.7.5	Provisions shall be made for all staff members to improve their competencies, through means such as...	3	0
2.1.1	The primary responsibility of the living unit staff shall be to devote their attention to the care and development of the residents.	8	0
2.1.1.1	Each resident shall receive appreciable and appropriate attention each day from the staff in the living unit.	14	1
2.1.1.2	Living unit personnel shall train residents in activities of daily living and in the development of self-help and social skills.	31	3
2.1.1.3	Living unit personnel shall be responsible for the development and maintenance of a warm, family- or home-like environment that is conducive to the achievement of optimal development by the resident.	21	4
2.1.1.4	Appropriate provisions shall be made to ensure that the efforts of the staff are not diverted from these responsibilities by excessive housekeeping and clerical duties, or other non-resident care activities.	16	2
2.1.1.5	The objective in staffing, each living unit should be to maintain reasonable stability in the assignment of staff, thereby permitting the development of a consistent inter-personal relationship between each resident and one or two staff members.	13	2
2.1.2.1	There shall be specific evaluation and program plans for each resident that are:	32	9
2.1.2.1.1	Available to direct care staff in each living unit;	27	1
2.1.2.1.2	Reviewed by a member or members of the interdisciplinary program team at least monthly, with documentation of such review entered in the resident's record.	32	5
2.1.2.2	Activity scheduled for each resident shall be available to direct care staff and shall be implemented daily.	19	4
2.1.3	The "rhythm of life" in the living unit shall resemble the cultural norm for the residents' nonretarded age peers, unless a departure from this rhythm is justified on the basis of maximizing the residents' human qualities.	22	1

* Non-accredited facilities.
**Accredited facilities.

Appendix 5

651 STANDARDS CLASSIFIED ACCORDING TO TOPICAL REQUIREMENTS FOR RESIDENTIAL FACILITIES

I. PROVISION OF ACTIVE HABILITATION PROGRAMMING TO EACH RESIDENT (381)

A. General Requirements (28)

1.1.1
1.1.5
1.1.5.1
1.3.1
1.3.1.1.2
2.1.1
2.1.1.1
2.1.1.4
2.1.1.5
2.2.2.7.3
2.2.2.7.5
2.2.4.2.2
2.2.4.2.3
2.5.1
3.1.3.4
3.4.1
3.4.1.1
3.4.1.2
3.4.2.5
3.4.2.7
3.9.1.2.3 OT
3.9.1.2.3 PT
3.11.2
3.11.2.3
3.15.1
3.15.1.1
3.15.1.1.2
3.15.1.1.3

B. Interdisciplinary Process Requirements (10)

3.1.2.1
3.1.2.3
3.3.3.1
3.3.3.2
3.6.5.1
3.9.4.4 OT
3.9.4.4 PT
3.10.3
3.11.9
3.13.8

C. Evaluation and Program Planning Requirements (53)

1.3.3
1.3.3.2
1.3.3.3
1.3.3.6
1.3.4
1.3.5.1
1.3.5.2
1.3.5.3
1.3.5.6.1
1.3.5.6.2
1.3.6
1.3.6.1
1.3.6.3.1
1.3.8.1
1.3.8.2.1
2.1.2.1
2.1.2.1.1
2.2.2.1.1
2.2.2.1.2
2.2.2.1.3
2.2.4.1
3.3.4.1
3.3.4.2
3.3.4.3
3.3.4.4
3.3.4.5
3.3.4.6.2
3.3.5
3.3.6
3.4.3.1
3.6.6.1
3.6.6.2
3.6.6.3
3.6.6.6
3.6.6.7
3.6.7.1
3.6.7.2
3.8.2
3.10.2.1
3.10.3.1.1
3.10.3.3.1
3.10.3.4.1
3.10.4
3.10.4.1
3.10.4.2
3.14.4.1.1
3.14.4.1.4
3.14.4.2.1
3.14.4.2.3
3.14.6
3.14.7.1
3.14.7.2
3.15.6

D. Management of Program Delivery Requirements (14)

2.1.2.1.2
2.1.2.2
2.5.3
2.6.1.1
3.7.7.2.2
3.7.7.2.3
3.9.8.5.1 OT
3.9.8.5.1 PT
3.9.8.5.2 OT
3.9.8.5.2 PT
3.11.12.2.1
3.11.12.2.2
3.15.11
4.4.1.4

E. Resident Training Requirements (14)

2.1.1.2
2.1.3.1
2.1.5
2.1.7.1.2
2.3.1.4
2.3.3
2.4.1.1
2.4.1.5.1
2.4.1.5.2
2.4.1.6
2.4.2.1
2.4.3.1
3.3.7.3
3.3.7.4

F. Behavior Management Requirements (17)

2.1.8
2.1.8.1
2.1.8.1.1
2.1.8.1.2
2.1.8.5
2.1.8.6
2.1.8.6.1
2.1.8.6.1.1
2.1.8.6.1.1.1
2.1.8.6.1.2
2.1.8.6.1.3
2.1.8.6.1.4
2.1.8.6.2
2.1.8.8
2.1.8.9.3
2.1.8.9.4
2.1.8.9.5

G. Attention to Resident Health Needs Requirements (75)

2.1.8.7.1
2.1.8.7.2
2.2.2
2.4.1.2

73

G. (cont'd)

2.4.1.4	3.4.5	3.6.4.2	3.6.11.2	3.7.7.2.1
2.4.2.6	3.4.6	3.6.4.3	3.6.11.3.1	3.8.1.1
2.4.2.7	3.4.8.1	3.6.8	3.6.11.3.2	3.8.4.2
2.4.3.2	3.6.1	3.6.8.1	3.7.1	3.8.6.1
2.4.4.3	3.6.1.1	3.6.8.2	3.7.1.3	3.8.6.1.1
2.4.5	3.6.1.2	3.6.8.3	3.7.1.4	3.8.6.1.2
2.4.6	3.6.1.3	3.6.8.4	3.7.2	3.8.6.3
3.2.1	3.6.2.1	3.6.9.1	3.7.2.1	3.8.6.3.1
3.2.3.1	3.6.2.2	3.6.9.2	3.7.2.2.1	3.8.6.3.2
3.2.3.2	3.6.3.1	3.6.9.2.2	3.7.3.1	3.8.6.4
3.2.3.3	3.6.3.2	3.6.9.4	3.7.4.2.5.1	3.8.6.10
3.2.4.3	3.6.3.4.1	3.6.9.5	3.7.4.2.5.2	
3.2.5.2	3.6.3.6	3.6.9.6	3.7.4.2.5.3	
3.2.6.4	3.6.4	3.6.10.2	3.7.4.3	
3.2.10	3.6.4.1	3.6.11	3.7.4.4	

H. Habilitation Services Requirements (68)

1.4.2.3	3.3.2.1	3.9.1.1.3 OT	3.13.2.1	3.16.2.1
1.4.2.4	3.3.7	3.9.1.1.3 PT	3.13.2.2	3.16.2.2
1.4.6.2	3.3.7.2	3.9.1.2 OT	3.14.1	3.16.3
2.2.1	3.3.7.5	3.9.1.2 PT	3.14.2.1	3.16.3.4
2.2.1.1.1	3.4.4.1	3.9.1.2.1 OT	3.14.2.2	
2.2.1.1.4	3.4.4.4	3.9.1.2.1 PT	3.15.1.1.1	
2.2.1.1.5	3.4.4.5	3.9.8.2 OT	3.15.2	
3.1.1	3.4.4.6	3.9.8.2 PT	3.15.7	
3.1.1.3	3.5.1	3.10.1	3.15.8	
3.1.1.3.1	3.6.8.5	3.10.9.1	3.15.9	
3.1.3.1	3.9.1.1 OT	3.11.1	3.15.9.7	
3.1.3.2	3.9.1.1 PT	3.11.2.1	3.15.9.7.1	
3.1.3.3	3.9.1.1.1 OT	3.11.3.1	3.15.9.7.2	
3.2.1.1	3.9.1.1.1 PT	3.11.4.18	3.15.10	
3.3.1	3.9.1.1.2 OT	3.12.1	3.16.1	
3.3.1.1	3.9.1.1.2 PT	3.13.1	3.16.2	

I. Staff Training and Consultation Requirements (18)

1.4.7	3.10.1.1.1
1.4.7.1	3.10.1.1.2
1.4.7.2	3.10.10.
1.4.7.3	3.16.7.1
1.4.7.5	3.16.8
2.2.4.2	
3.14.3	
3.7.3.2	
3.7.8	
3.9.1.3.2 OT	
3.9.1.3.2 PT	
3.9.8.4.1 OT	
3.9.8.4.1 PT	

J. Staffing Requirements (43)

2.2.1.2	3.6.11.1.1	3.10.9.7.1	5.3.2.1
2.6.1	3.6.11.1.2	3.10.9.8	
3.2.10.1	3.6.11.2.1	3.11.12	
3.2.11	3.7.7	3.13.13	
3.2.11.1	3.7.7.1	3.13.13.7	
3.2.11.2	3.7.7.4	3.14.10	
3.2.11.7	3.8.1	3.14.10.2	
3.3.8	3.8.8.1	3.14.10.4	
3.3.8.1.1	3.8.8.4	3.14.10.5	
3.3.8.1.2	3.9.8	3.15.8.8	
3.3.8.3	3.9.8.1.1 OT	3.16.3.2	
3.4.12	3.9.8.1.1 PT	3.16.3.3	
3.4.12.4	3.9.8.1.2	3.16.10	
3.4.12.7	3.10.9	3.16.10.1	

K. Documentation Requirements (31)

1.3.5.5	4.2.2
1.3.6.3.2	4.2.2.1
1.3.8	4.2.2.2
1.3.8.3.2	4.2.2.3
3.2.8	4.2.3.1
3.2.8.2	4.2.3.2
4.1.1	4.2.3.3
4.1.1.1	4.2.3.4
4.1.1.2	4.2.3.5
4.1.1.3	4.2.3.7
4.1.1.4	4.2.3.9
4.1.2	4.2.4
4.1.3.1	4.2.4.1
4.1.3.2	
4.1.3.3	
4.2.1.5	
4.2.1.12	
4.2.1.13	

L. Facilities and Equipment Requirements (10)

1.3.1.1.1
2.2.2.7.6
2.4.3.4
2.4.7
2.7.5
3.4.15.1.4
3.8.10.4
3.8.12.1
3.11.17
3.11.18

II. PROVISION OF SERVICES WITHIN A NORMALIZED AND NORMALIZING ENVIRONMENT (57)

A. General Normalization Requirements (17)

1.1.1.1
2.1.1.3
2.1.3.6
2.1.7
2.2.2.7.4
2.2.4.2.1
2.3.1
2.3.1.1
2.3.1.2
2.3.1.3
2.3.1.5
2.4.1.2.1
2.4.1.3
2.4.1.6.1
3.3.7.7
3.4.8.2
3.4.8.3

B. Community Integration Requirements (6)

1.1.3.5
1.1.4.7
1.2.10
1.2.11.4
3.1.1.2
3.15.13

C. Integration of Multihandicapped Requirements (7)

2.4.3.3
2.5.2.2
2.7.5.3
2.7.5.4.1
2.7.5.5.1
3.2.14.4
6.1.6

D. Rhythm of Life Requirements (9)

2.1.3
2.1.3.2.1
2.1.3.2.2
2.1.3.2.3
2.1.3.2.4
2.1.3.3
2.2.2.4
2.2.2.4.1
2.2.2.4.2

E. Physical Environment Requirements (18)

2.1.6
2.2.3
2.2.3.1
2.4.1.5.3
2.4.3
2.5.4
2.7.2.3
2.7.3.8.1
2.7.3.8.2
2.7.3.8.3
2.7.3.9.1
2.7.3.9.2
2.7.5.2
2.7.5.4.2
2.7.5.4.3
2.7.6.1
2.7.6.2
7.7.1.1

III. ASSURANCE OF THE RIGHTS OF RESIDENTS AND THEIR FAMILIES (69)

A. General Rights-Assurance Requirements (13)

1.3.2
1.3.8.2.2
1.3.8.3.3
1.3.9.1
2.2.2.2
3.10.3.4.6
4.1.1.6
4.2.3.10
4.3.1
4.3.1.1
4.3.1.2
4.3.1.3
5.4.2

B. Rights of Residents Requirements (40)

1.2.1.2	1.3.6.2.3	1.4.6.3.3	3.12.6.1
1.2.2.1	1.3.6.3.4	1.4.6.3.4	4.2.1.6
1.2.2.1.1	1.3.8.3.1	1.4.6.4.2	4.2.1.7
1.2.2.1.2	1.4.5	2.1.5.1	4.3.1.4
1.2.2.2	1.4.5.1	2.1.5.2	
1.2.2.2.2	1.4.5.1.1	2.1.5.3	
1.2.2.2.3	1.4.5.1.2	2.1.5.4	
1.2.11.4.1	1.4.5.1.3	2.1.8.3	
1.2.11.4.2	1.4.6	2.1.8.4	
1.3.2.2	1.4.6.1	2.1.8.9.1	
1.3.6.2.1	1.4.6.3.1	2.2.2.3	
1.3.6.2.2	1.4.6.3.2	3.12.4.1	

C. Rights of Families Requirements (16)

1.2.1.4
1.2.11.6
1.2.11.8
1.2.11.11
1.3.3.7
1.3.5.6.3
1.3.6.3.3
1.3.6.4
1.3.8.1
1.3.9
1.3.9.2.1
1.3.9.2.3
1.3.9.2.4
2.1.8.1.3
2.1.8.9.2
7.2.8

IV. EFFECTIVE ADMINISTRATIVE PRACTICES (69)

A. General Administrative Requirements (39)

1.2.1	1.4.2.1	7.4.2.2
1.2.1.1	1.4.2.6	7.5.1
1.2.1.3	1.4.2.8	7.7.1.2
1.2.2	1.4.3	
1.2.3	1.4.4	
1.2.5	1.4.4.1	
1.2.6	1.4.4.2	
1.2.6.1	3.1.3	
1.2.6.1.1	3.10.7.3.4	
1.2.6.1.2	7.1.1	
1.2.6.2	7.2.4	
1.2.7.1	7.2.5	
1.2.7.2	7.2.5.1	
1.2.7.3.1	7.2.6	
1.2.8	7.2.7	
1.3.9.3	7.2.9	
1.4.1	7.4.1	
1.4.2	7.4.2.1	

B. Communications Requirements (2)

1.2.8.4
1.2.8.4.6

C. Records Requirements (20)

1.2.9.7	4.2.1.3	4.4.1.1	4.6.1
3.3.4.6.1	4.2.1.4	4.4.1.3	4.6.1.1
4.1.1.7	4.2.2.4	4.4.1.5	
4.1.4	4.2.5.1	4.4.1.6	
4.2.1.1	4.2.5.2	4.4.1.7	
4.2.1.2	4.4.1	4.5.2	

D. Research Requirements (8)

5.1.1.2.1
5.1.1.2.2
4.1.1.2.3
5.2.1
5.2.1.2
5.2.2
5.3.1
5.3.2.2

V. MAINTENANCE OF A SAFE AND SANITARY ENVIRONMENT (75)

2.2.2.8
2.2.5
2.2.5.1
2.7.6.2.2
2.7.6.4.1
2.7.6.5
2.7.6.6
2.7.6.7
2.7.6.7.1
2.7.6.8
3.4.4.7
3.4.9
3.4.9.1
3.4.9.2
3.4.9.3
3.4.10
3.4.11
3.4.11.1
3.4.11.2
3.4.11.3
3.4.12.6
3.4.12.6.1
3.4.15.1.3
3.4.15.1.5
3.8.6
3.8.6.3.3
3.8.6.3.4
3.8.6.5
3.8.6.5.1
3.8.6.5.2
3.8.6.5.3
3.8.6.5.4
3.8.6.5.5
3.8.6.5.6
3.8.6.7
3.8.6.8
3.8.6.11
3.8.7.1
3.8.7.2
6.1.1
6.1.1.1
6.1.1.2
6.1.1.3
6.1.2
6.1.2.1
6.1.2.2
6.1.2.3
6.1.2.4
6.1.3
6.1.3.1.1
6.1.3.1.2
6.1.3.1.3
6.1.3.1.4
6.1.3.1.5
6.1.3.1.6
6.1.3.2
6.1.4
6.1.4.1
6.1.4.2
6.1.4.4.1
6.1.4.5
6.1.5
6.1.5.1
6.1.5.2
6.1.7
6.1.7.1
6.1.8
6.2.1
6.2.1.1
6.2.2
6.2.2.1.1
6.2.2.1.2
6.2.3.2
6.2.3.4
6.2.4